TABLE OF CONTENTS

1000 INTRODUCTION TO ICEMA PROTOCOLS
1001 General Patient Guidelines 12/01/01

2000 STANDARD DRUG & EQUIPMENT LIST
2001 BLS & ALS Standard Drug and Equipment List 11/01/04
2003 EMS Aircraft Standard Drug and Equipment List 09/01/99

3000 MEDICATION REFERENCES
3001 ALS Medication Reference 05/01/06

4000 PROCEDURES AND SKILLS
4001 External Jugular Vein Access 10/01/05
4005 Transcutaneous Cardiac Pacing 10/01/05
4009 Oral Endotracheal Intubation - Adult 10/01/05
4011 Oral Endotracheal Intubation - Pediatric 10/01/05
4013 Tracheal Instillation of Medications 10/01/05
4019 Synchronized Cardioversion 10/01/05
4021 Insertion of Nasogastric/Orogastric Tube 10/01/05
4023 Needle Thoracostomy 10/01/05
4026 Intraosseous Infusion 10/01/05
4029 Nasotracheal Intubation 10/01/05
4030 Needle Cricothyrotomy 10/01/05
4033 Vagal Maneuvers 10/01/05
4035 Axial Spinal Stabilization 11/01/04
4036 Pulse Oximetry 02/15/04
4050 Esophageal Tracheal Airway Device (ETAD) 10/01/05

5000 MEDICAL EMERGENCIES
5001 Adult Respiratory Emergencies 10/01/05
5003 Shock (Non-Traumatic) 07/01/00
5007 Altered Level of Consciousness/Seizures 11/01/04
5009 Poisonings (ALS) 03/01/99
5016 Adult Airway Obstruction 09/18/06
5018 Heat Related Emergencies 11/01/04
5019 Cold Related Emergencies 05/01/06
5209 Poisonings (BLS) 04/15/96

6000 CARDIAC EMERGENCIES - ADULT
6001 Suspected Acute MI 05/01/06
6004 Adult Tachycardias 05/01/06
6007 Non-Traumatic Hypertensive Crisis 05/01/06
6011 Adult Bradycardia 05/01/06
6015 Adult Cardiac Arrest 09/18/06
6301 Automatic External Defibrillation AED 09/01/02

7000 PEDIATRIC EMERGENCIES

7001 Pediatric Cardiac Arrest (1 Day to 8 years of Age)	09/18/06
7002 Pediatric Cardiac Arrest (9 to 15 years of Age)	12/01/01
7007 Pediatric Altered Level of Consciousness	11/01/04
7008 Pediatric Respiratory Emergencies	11/01/04
7010 Pediatric Seizure	11/01/04
7011 Pediatric Allergic Reaction	11/01/04
7015 Pediatric Airway Obstruction	09/18/06

8000 TRAUMA

8001 Adult Trauma	11/01/04
8003 Pediatric Trauma	11/01/04
8010 Adult Trauma Triage Criteria	11/01/04
8011 Glasgow Coma Scale Operational Definition	04/15/96
8012 Pediatric Trauma Triage Criteria	11/01/04
8215 Fractures and Dislocations	09/01/85

11000 OBSTETRICAL/NEONATAL EMERGENCIES

11001 Newborn Care	11/01/04
11003 Obstetrical Emergencies	01/01/06

12000 MCI/HAZMAT

12001 Medical Response to a Multi-Casualty Incident	11/01/04
12003 Medical Response to a Haz-Mat Incident	07/01/01

13000 TRANSFER OF PATIENTS

13001 EMT-P Interfacility Transport Guidelines	05/01/06
13009 Interfacility Transport - Nurse Staffed Units	05/01/06

14000 POLICIES AND PROCEDURES

14001 Physician on Scene	11/01/04
14002 Suspected Sudden Infant Death Syndrome Incident	11/01/04
14003 Responsibility for Patient Management	11/01/04
14004 Reporting Incidents of Suspected Abuse/N eg1ect	11/01/04
14005 Patient Refusal of Care or Other Patient Request	04/15/96
14006 Guidelines for Adult Refusal of Care	01/01/06
14007 Withholding Resuscitative Measures	05/01/06
14008 Do Not Resuscitate (DNR) Policy	07/01/01
Do Not Resuscitate Report Form	07/01/01
14009 Radio Communication	11/01/04
14010 Protocol Update Curriculum	02/01/03
14010 Annual Review Class	05/01/06
14011 Continuing Education Provider Policy	04/01/05
CE Class Roster Form	04/01/05
Monthly CE Class Log Form	04/01/05
14012 Requirements for Patient Care Records	05/01/06

14013 Instructions for the 01A/F1612 Forms	07/01/02
14015 01A & F1612 Run Report Forms - Samples	01/01/99 & 03/01/02
14017 Incident Reports	
14023 Care of Minors in the Field	05/01/06
14027 Organ Donor Information	10/01/05
14029 Local Medical Emergency	08/01/93
14031 Denial of Pre hospital Care Certification	09/01/93
14033 Guidelines on Applying Patient Restraints	05/01/06
14040 Controlled Substance Policy	05/01/06
14050 Down-Licensing/Closure, 911 Receiving Hospitals	11/15/99
14051 Hospital Diversion Policy	04/01/05
14060 San Bernardino County Ambulance Mutual Aid Policy	11/15/99
14308 Esophageal Tracheal Airway Device (ETAD) Service Provider	02/01/03
14309 Pulse Oximetry Service Provider	02/15/04
14310 Automatic External Defibrillation (AED) Service Provider	09/01/02
14312 Public Safety AED Service Provider	09/01/02

15000 ACCREDITATION AND CERTIFICATION REQUIREMENTS

15101 Emergency Medical Dispatcher Certification Requirements	01/01/93
15111 First Responder Certification Criteria	05/01/94
15113 First Responder Recertification Criteria	05/01/94
15201 EMT-I Certification Requirements	04/01/05
15203 EMT-I Certification Challenge Requirements	04/01/05
15205 Maintaining EMT-I Certification	04/01/05
EMT-I Skills Competency Verification Form EMSA-SCV (07/03)	04/01/05
15207 EMT-I Continuing Education Requirements	04/01/05
15301 Requirements for EMT-P Accreditation	05/01/06
15401 Requirements for MICN Certification	05/01/06

GENERAL PATIENT CARE GUIDELINES

PURPOSE
To provide guidelines for the minimum standard of care for all patient contacts

AUTHORITY
Title 22, Division 9, Chapter 4, Sections 1001, 100146 and 100147

DEFINITIONS

Patient: Any individual with a complaint of pain, discomfort or physical ailment
Any individual regardless of complaint with signs and/or symptoms of pain, discomfort, physical ailment or trauma. These signs/symptoms include, but are not limited to:

a. Altered level of consciousness
b. Sign and/or symptoms of skeletal or soft tissue injuries
c. Altered ability to perceive illness or injury due to the influence of drug, alcohol or other mental impairment
d. Evidence that the individual was subject to significant force

Patient Contact: Achieved when any on duty BLS or ALS field provider comes into the presence of a patient as defined above

BLS INTERVENTIONS

1. Obtain a thorough assessment of the following:
   a. Airway, breathing and circulatory status
   b. Subjective assessment of the patients' physical condition and environment
   c. Objective assessment of the patients' physical condition and environment
   d. Vital signs
   e. Prior medical history, and current medications
   f. Any known medication allergies or adverse reactions to medications, food or environmental agents
2. Initiate care using the following tools as clinically indicated or available
   a. Axial spinal immobilization
   b. Airway control with appropriate BLS airway adjunct
   c. Oxygen
   d. Assist the patient into a physical position that achieves the best medical benefit and maximum comfort
   e. Automated External Defibrillator (AED)
   f. Consider the benefits of early transport and/or intercept with ALS personnel if clinically indicated
3. Assemble necessary equipment for ALS procedures under direction of EMT-P
   a. Cardiac monitoring
   b. IV/IO
   c. Endotracheal Intubation
   d. Pulse Oximetry
4. Under EMT-P supervision, assemble pre-load medications as directed, excluding controlled substances.

ALS INTERVENTIONS

1. Evaluation and continuation of all BLS care initiated
2. Augment BLS assessment with an advanced assessment including but not limited to the following:
   a. Qualitative lung assessment
   b. Cardiac monitor
   c. Blood glucose monitoring
3. Augment BLS treatment with advanced treatments as indicated or available
4. Initiate airway control as needed with the appropriate ALS adjunct
5. Initiate vascular access as clinically indicated

STANDARD DRUG & EQUIPMENT LIST

Each Unit will be equipped with the following functional equipment and supplies. **This list represents mandatory items with minimum quantities**, to exclude narcotics, which must be kept within the range indicated. All expiration dates must be current. All packaging of drugs or equipment must be intact. No open products or torn packaging may be used.

MEDICATIONS/SOLUTIONS

Exchanged Medications/Solutions	BLS Transport	ALS Non-Transport	ALS Transport
Activated Charcoal		50gm	50gm
Adenosine (Adenocard)		30mg	30mg
Adrenaline (Epinephrine) 1:1000		30mg	30mg
Adrenaline (Epinephrine) 1:1000		2mg	2mg
Adrenaline (Epinephrine) 1:10,000		3mg	3mg
Albuterol Aerosolized Solution (Proventil)-unit dose 2.5mg		4	4
Aspirin, chewable - 81mg tablet		1bottle	1bottle
Atropine .4mg/1cc		2	2
Atropine		3mg	3mg
Calcium Chloride		1gm	1gm
Dextrose 25%		5.0gm	5.0gm
Dextrose 50%		50gm	50gm
Diphenhydramine (Benadryl)		50mg	50mg
Furosemide (Lasix)		80mg	80mg
Glucagon		1mg	1mg
Glucose paste	1 tube		
Intropin (Dopamine)		400mg	400mg
Lidocaine		300mg	300mg
Lidocaine/ or 1 bag pre-mixed		2gm	2gm
Lidocaine 2% (Viscous)		2oz	2oz
Magnesium Sulfate		10gms	10gms
Naloxone (Narcan)		4mg	10mg
Nitroglycerine – Spray or Tablets		1bottle	2 bottles
10cc Normal Saline for Injection		2	2
Phenylephrine HCI (Neosynephrine) - 0.5mg per metered dose		1bottle	1bottle
Procainamide		1gm	2gm
Sodium Bicarbonate		100mEq	100mEq
Verapamil (Isoptin)		15mg	15mg
1000c Irrigating Saline and/or Sterile Water	2	1	2
Normal Saline 100cc		1	2
Normal Saline 250cc		1	1
Normal Saline 1000cc		3	6

Controlled Substance Medications

Non-exchange – must be kept double locked	BLS Transport	ALS Non-Transport	ALS Transport
Midazolm – vials of 10mg/2cc, 2mg/2cc, or 5mg/5cc		20-44mg	20-44mg
Morphine Sulfate – ampules of 10mg or 15mg		30-60mg	30-60mg

AIRWAY/SUCTION EQUIPMENT

Exchanged Equipment	BLS Transport	ALS Non-Transport	ALS Transport
Oropharyngeal Airways – (infant, child, and adult)	1 each	1 each	1 each
Nasopharyngeal Airways – (infant, child, and adult)	1 each	1 each	1 each
Nasal cannulas – pediatric and adult	2 each	2 each	2 each
Pediatric non-rebreather O2 mask	2	2	2
Adult non-rebreather mask	2	2	2
Endotracheal tubes, uncuffed – ~~2.0,~~ 2.5, 3.0, 3.5		3 each	3 each
Endotracheal Tubes, uncuffed – 4.0 or 4.5, 5.0 or 5.5		2 each	2 each
Endotracheal Tubes cuffed – 6.0, 7.0, 7.5 and 8.0		2 each	2 each
Ventilation Bags – Infant 250ml, Pediatric 500ml (or equivalent) Adult 1L	1 each 1 each	1 each 1 each	1 each 1 each
Approved Needle Cricothyrotomy Device – Pediatric and adult *or* Needles for procedure 10ga, 12ga, 14ga, 15ga		1 each 2 each	1 each 2 each
Malleable Stylet – pediatric and adult		1 each	1 each
ET Tube holders – pediatric and adult		1 each	2 each
BAAM Device		1	2
Small volume nebulizer with universal cuff adaptor		2	2
One way flutter valve with adapter or equivalent		1	1
Naso/Orogastric tubes - 10fr or 12fr, 14fr, 16fr or 18fr		1 each	1 each
Naso/Orogastric feeding tubes - 5fr or 6fr, and 8fr		1 each	1 each
Suction catheters - 6fr, 8fr or 10fr, 12fr or 14fr	1 each	1 each	1each
Yaunkers tonsil tip	1	1	1
Water soluble lubricating jelly		1	1

Non-Exchange Equipment	BLS Transport	ALS Non-Transport	ALS Transport
Ambulance Oxygen source –10L/min for 20 minutes	1		1
Portable Oxygen with regulator – 10L/min for 20 minutes	1	1	1
Pulse Oximetry device		1	1
End-title CO2 device – pediatric and adult (may be integrated into bag)		1 each	1 each
Stethoscope	1	1	1
Flashlight/penlight	1	1	1
Laryngoscope handle with batteries – or 2 disposable handles		1	1
Laryngeal blades - #0, #1, #2, #3, #4 curved and/or straight		1 each	1 each
Magill Forceps – Pediatric and Adult		1 each	1 each
Wall mount suction device	1		1
Portable suction device (battery operated)	1	1	1

IV /NEEDLES/ SYRINGES/MONITORING EQUIPMENT

Exchanged Equipment	BLS Transport	ALS Non-Transport	ALS Transport
Syringes w/wo safety needles – 1cc, 3cc, 10cc, 20cc, 60cc catheter tip		2 each	2 each
Safety Needles – 20ga or 21ga and 23ga or 25ga		2 each	2 each
IV Catheters – sizes 14, 16, 18, 20, 22, 24		2 each	2 each
IO Needles – Pediatric and Adult 3-way stopcock IV extension tubing		2 each 1 2	2 each 1 2
Microdrip Administration Set (60 drops/cc) Macrodrip Administration Set (10 drops/cc)		1 3	2 3
Blood Tubing (Y type)			2
Saline Lock		2	2
EKG patches – Pediatric and Adult		3 sets each	3 sets each
Conductive medium *or* Pacer/Defibrillation pads		 2	 2

Non-Exchange Equipment	BLS Transport	ALS Non-Transport	ALS Transport
Blood pressure cuff – large adult or thigh cuff, adult, child and infant	1	1	1
Pressure infusion bag			1
OSHA approved needle disposal system		1	1
Thermometer	1	1	1
Glucose monitoring device		1	1
Defibrillator (adult and pediatric capabilities) with TCP and printout		1	1

Optional Non-exchange Equipment/Medications	BLS Transport	ALS Non-Transport	ALS Transport
Ammonia Inhalants		2	2
Bone Injection Gun (Adult and Peds 2 each)		2	2
Buretrol		1	1
Pitocin		20 units	20 units
Approved automatic ventilator		1	1
D5W in bag		1	1
Esophageal Tracheal Airway Device (ETAD) LA Esophageal Tracheal Airway Device (ETAD) SA		2 2	2 2
IV infusion pump		1	1
IV warming device		1	1
Chemistry profile tubes		3	3
Vacutainer		1	1
Manual powered suction device	1	1	1
Multi-lumen peripheral catheter		2	2
Needle Thoracostomy Kit (prepackaged)		2	2
Translaryngeal Jet Ventilation Device		1	1
12 –Lead EKG Monitor		1	1
AED/defib pads	1		
CAREvent^{R} BLS/ALS Handheld Resuscitator	1	1	1

DRESSING MATERIALS/ OTHER EQUIPMENT/SUPPLIES

Exchanged Items	BLS Transport	ALS Non-Transport	ALS Transport
Antiseptic swabs/wipes			
Provodine/Iodine swabs/wipes			
Air occlusive dressing (Vaseline gauze)	1	1	1
Sterile bandage compress or equivalent	6	2	6
Sterile gauze pads – 4x4 inch	4	4	4
Roller bandages – 4 inch	6	3	6
Adhesive tape – 1 inch	2	2	2
Universal Dressing 10x30 inches	2	2	2
Cervical Collars – Rigid Pediatric & Adult *or* Cervical Collars – Adjustable Adult & Pediatric	2 each 2 each	2 each 2 each	2 each 2 each
Head immobilization device	2	2	2
Sterile Sheet for Burns	2	2	2
OB Kit	1	1	1
Emesis basin or disposable bags & covered waste container	1	1	1
Ankle & wrist restraints, soft ties acceptable	1	0	1
Pneumatic or rigid splints capable of splinting all extremities	4	2	4
Bedpan or fracture pan Urinal	1 1		1 1

Non-exchange Equipment/Supplies	BLS Transport	ALS Non-Transport	ALS Transport
Bandage Shears	1	1	1
Short extrication device	1	1	1
Traction splint	1	1	1
Triage Tags	30	30	30
Blood Borne Pathogen Protective Equipment - (nonporous gloves, goggles face masks & gowns meeting OSHA Standards)	2	2	2
Drinkable water in secured plastic container or equivalent	1 gallon		1 gallon
Ambulance gurney	1		1
Straps to secure patient to gurney	1 set		1 set
Pillow, pillow case, sheets & blanket	1 set		1 set
Long board with restraint straps	1	1	1
Pediatric immobilization board	1	1	1

Optional Equipment/Supplies	BLS Transport	ALS Non-Transport	ALS Transport
Backboard padding	1	1	1
Autopulse ™ Resusitation System	1	1	1

EMS AIRCRAFT STANDARD DRUG & EQUIPMENT LIST

Each Aircraft will be equipped with the following functional equipment and supplies. This list represents mandatory items with minimum quantities, to exclude narcotics, which must be kept within the range indicated. All expiration dates must be current. All packaging of drugs or equipment must be intact. No open products or torn packaging may be used.

MEDICATIONS/SOLUTIONS

Exchanged Medications/Solutions	Amount
Adenosine (Adenocard)	30mg
Adrenaline (Epinephrine) 1:1000	2mg
Adrenaline (Epinephrine) 1:10,000	3mg
Albuterol Aerosolized Solution (Proventil)-unit dose 2.5mg	4
Aspirin, chewable - 81mg tablet	1bottle
Atropine .4mg/1cc	2
Atropine	3mg
Calcium Chloride	1gm
Dextrose 25%	5.0gm
Dextrose 50%	50gm
Diphenhydramine (Benadryl)	50mg
Furosemide (Lasix)	40mg
Glucagon	1mg
Intropin (Dopamine)	400mg
Lidocaine	300mg
Lidocaine/ or 1 bag pre-mixed	2gm
Lidocaine 2% (Viscous)	2oz
Magnesium Sulfate	10gms
Naloxone (Narcan)	10mg
Nitroglycerine – Spray or Tablets	1bottle
10cc Normal Saline for Injection	2
Phenylephrine HCI (Neosynephrine) - 0.5mg per metered dose	1bottle
Procainamide	1gm
Sodium Bicarbonate	100mEq
Verapamil (Isoptin)	15mg
Normal Saline 250cc	1
Normal Saline 1000cc	4

Controlled Substance Medications

Non-exchange – must be kept double locked	Amount
Midazolm – vials of 10mg/2cc, 2mg/2cc, or 5mg/5cc	20-44mg
Morphine Sulfate – ampules of 10mg or 15mg	30-60mg

AIRWAY/SUCTION EQUIPMENT

Exchanged Equipment	**Amount**
Oropharyngeal Airways – (infant, child, and adult)	1 each
Nasopharyngeal Airways – (infant, child, and adult)	1 each
Nasal cannulas – pediatric and adult	2 each
Pediatric non-rebreather O2 mask	2
Adult non-rebreather mask	2
Endotracheal tubes, uncuffed – 2.0, 2.5, 3.0, 3.5	2 each
Endotracheal Tubes, uncuffed – 4.0 or 4.5, 5.0 or 5.5	2 each
Endotracheal Tubes cuffed – 6.0, 7.0, 7.5 and 8.0	2 each
Ventilation Bags – Infant 250ml, Pediatric 500ml (or equivalent) Adult 1L	1 each 1 each
Approved Needle Cricothyrotomy Device – Pediatric and adult *or* Needles for procedure 10ga, 12ga, 14ga, 15ga	1 each 2 each
Malleable Stylet – pediatric and adult	1 each
ET Tube holders – pediatric and adult	1 each
BAAM Device	1
Small volume nebulizer with universal cuff adaptor	2
One way flutter valve with adapter or equivalent	1
Naso/Orogastric tubes - 10fr or 12fr, 14fr, 16fr or 18fr	1 each
Naso/Orogastric feeding tubes - 5fr or 6fr, and 8fr	1 each
Suction catheters - 6fr, 8fr or 10fr, 12fr or 14fr	1 each
Yaunkers tonsil tip	1
Water soluble lubricating jelly	1

Non-Exchange Equipment	Amount
Aircraft Oxygen source –10L/min for 20 minutes	1
Portable Oxygen with regulator – 10L/min for 20 minutes	1
Pulse Oximetry device	1
End-title CO2 device – pediatric and adult (may be integrated into bag)	1 each
Stethoscope	1
Flashlight/penlight	1
Laryngoscope handle with batteries – or 2 disposable handles	1
Laryngeal blades - #0, #1, #2, #3, #4 curved and/or straight	1 each
Magill Forceps – Pediatric and Adult	1 each
Wall mount suction device	1
Portable suction device (battery operated)	1

IV /NEEDLES/ SYRINGES/MONITORING EQUIPMENT

Exchanged Equipment	**Amount**
Syringes w/wo safety needles – 1cc, 3cc, 10cc, 20cc, 60cc catheter tip	2 each
Safety Needles – 20ga or 21ga and 23ga or 25ga	2 each
IV Catheters – sizes 14, 16, 18, 20, 22, 24	2 each
IO Needles – Pediatric and Adult 3-way stopcock IV extension tubing	2 each 1 2
Microdrip Administration Set (60 drops/cc) Macrodrip Administration Set (10 drops/cc)	1 3
Blood Tubing (Y type)	
Saline Lock	2
EKG patches – Pediatric and Adult	3 sets each
Conductive medium *or* Pacer/Defibrillation pads	 2

Non-Exchange Equipment	**Amount**
Blood pressure cuff – large adult or thigh cuff, adult, child and infant	1
Pressure infusion bag	1
OSHA approved needle disposal system	1
Thermometer	1
Glucose monitoring device	1
Defibrillator (adult and pediatric capabilities) with TCP and printout	1

Optional Non-Exchange Equipment/Medications	**Amount**
Ammonia Inhalants	2
Bone Injection Gun (adult and peds)	2 each
Pitocin	20 units
Approved automatic ventilator	1
D5W in bag	1
Esophageal Tracheal Airway Device (ETAD) LA Esophageal Tracheal Airway Device (ETAD) SA	2 2
IV infusion pump	1
IV warming device	1
Chemistry profile tubes	3
Vacutainer	1
Manual powered suction device	1
Multi-lumen peripheral catheter	2
Needle Thoracostomy Kit (prepackaged)	2
Translaryngeal Jet Ventilation Device	1
12 –Lead EKG Monitor	1
AED/defib pads	1
CAREvent^{R} BLS/ALS Handheld Resuscitator	1

DRESSING MATERIALS/ OTHER EQUIPMENT/SUPPLIES

Exchanged Items	**Amount**
Antiseptic swabs/wipes	
Provodine/Iodine swabs/wipes	
Air occlusive dressing (Vaseline gauze)	1
Sterile bandage compress or equivalent	6
Sterile gauze pads – 4x4 inch	4
Roller bandages – 4 inch	3
Adhesive tape – 1 inch	2
Universal Dressing 10x30 inches	2
Cervical Collars – Rigid Pediatric & Adult *or* Cervical Collars – Adjustable Adult & Pediatric	2 each 2 each
Head immobilization device	2
Sterile Sheet for Burns	2
OB Kit	1
Emesis basin or disposable bags & covered waste container	1
Ankle & wrist restraints, soft ties acceptable	1
Pneumatic or rigid splints capable of splinting all extremities	4

Non-Exchange Equipment/Supplies	**Amount**
Bandage Shears	1
Short extrication device	1
Traction splint	1
Blood Borne Pathogen Protective Equipment - (nonporous gloves, goggles face masks & gowns meeting OSHA Standards)	2
Aircraft stretcher or litter system with approved FAA sraps	1
Pillow, pillow case, sheets & blanket	1 set
Long board with restraint straps	1
Pediatric immobilization board	1

Optional Equipment/Supplies	**Amount**
Backboard padding	1
Autopulse ™ Resusitation System	1

ALS MEDICATION REFERENCES

ACTIVATED CHARCOAL- Adsorbent - Adsorbs toxic substances ingested into the gastrointestinal tract thus inhibiting any gastrointestinal adsorption.
Side effects: Will color stools black although medically insignificant. Be aware of possible aspiration.
Typical Preparations: 12.5, 25 or 50gm size squeeze bottles. Some preparations contain sorbitol.
Dose: Adult: 50gms PO
Pediatric: 1gm/kg PO

ADENOSINE - Naturally occurring nucleotide present in all cells of the body- Slows conduction through the AV node and dilates coronary arteries and peripheral vessels. Adenosine has a half-life of 10 to 12 seconds and is rapidly metabolized by blood and tissues to Inosine, a crystalline nucleotide. Used as the drug of choice in treating episodes of Narrow Complex Tachycardias. May also be considered for Stable V-Tach or Wide Complex Tachycardias.
Side Effects: Transient, lasting less than a minute, and may include chest pain, shortness of breath, flushing and various dysrhythmias including transient Asystole or V-Fib. Adenosine is often referred to as a "chemical cardioversion" Give with caution to patients with an asthma history, because of a potential for bronchospasm.
Typical Preparations: 6mg/1ml vials
Dose: Adult: 6mg rapid IV bolus to IV port closest to the patient, followed immediately by a rapid IV bolus of 20ml NS. If there is no change in rhythm within 2 minutes, give a 12mg rapid IV bolus followed as before with a rapid IV bolus of 20ml NS. May give a 3rd bolus of 12mg if there is no change in rhythm.

ALBUTEROL SULFATE - Bronchodilator- A $Beta_2$-adrenergic receptor stimulant that will affect the respiratory tract in the form of bronchial smooth muscle relaxation. Used as a bronchodilator for reversible, acute bronchospasms in patients with bronchitis, emphysema and asthma.
Side Effects: May cause palpations, hypertension, anxiety, nausea and dizziness. Always monitor vitals and use with caution for patients with a history of cardiovascular disease or hypertension.
Note: Other sympathomimetic aerosol bronchodilators or Epinephrine should not be used concomitantly with Albuterol. Beta blocking agents and Albuterol inhibit the effect of each other.

Typical Preparations: Premixed unit dose of 2.5mg in 2.5ml NS
Dose: Adult: Use 2.5mg of Albuterol solution in small volume nebulizer over 5-15 minutes.
Pediatric: Same as adult dose.

ASPIRIN - Antiplatlet- Indicated for any patient experiencing symptoms associated with myocardial infarction or transient ischemic episode.
Side Effects- Aspirin may cause nausea, vomiting or hemorrhage as well as exacerbate pain in patients with a history of GI irritation. Aspirin should not be given to any patient with a history of GI hemorrhage, intracranial hemorrhage, major surgery within the last 1-2 weeks, history of aortic aneurysm, or previous thrombosis.
Typical Preparations- Bottle of 81mg chewable tablets
Dose: Adult: 162mg (two 81mg chewable tablets)
Pediatric: Not recommended in the pre-hospital setting

ATROPINE SULFATE- Parasympathetic agent- Atropine Inhibits the effects of parasympathetic nervous system by blocking acetylcholine receptors. It increases the heart rate in certain bradycardias. In addition, Atropine is also used in the treatment of organophosphate and nerve agent poisonings.
Side Effects - The effects of Atropine are short acting. Consider TCP instead of Atropine for a documented MI, 3rd degree wide complex AV block, and 2nd degree type II AV block
Typical Preparations - 1mg/10ml preload syringe
Dose: Adult: Bradycardia: 0.5mg IV push to max of 3mg or 0.04mg/kg.
PEA, Asystole: 1mg IV push to max of 3mg or 0.04mg/kg.
Organophosphate/Nerve Agent Poisoning: 2mg IV push may repeat if patient remains symptomatic
Pediatric: Cardiac Emergencies: Not indicated for pediatric patients
Organophosphate Poisoning: 0.02mg/kg IV/IO, minimum dose 0.1mg

CALCIUM CHLORIDE- Cardiotonic agent- Calcium Chloride is an electrolyte necessary for myocardial contractions, increases myocardial contractile force, and may also enhance ventricular excitability. The calcium ion is essential for coupling the electrical event with mechanical contraction. Medication is used primarily for acute hyperkalemia, acute hypocalcemia, calcium channel blocker toxicity (Nifedipine, Verapamil, etc.)
Side Effects- May produce severe bradycardia, arrhythmias, cardiac arrest or syncope. Will precipitate if mixed with Sodium Bicarbonate, flush IV tubing prior to and after administration. If IV site becomes infiltrated, necrosis may occur around insertion site. May precipitate Digitalis toxicity
Typical Preparations- 10cc Calcium Chloride (1Gm/10ml) preload syringe
Dose: Adult: 8-16mg/kg (5-10ml) Base Hospital Order only

DEXTROSE 25% & 50%- Solutions of glucose in water- An immediate source of glucose which may be rapidly utilized for cellular metabolism. May consider in cases of altered mental status, consider in comas of unknown etiology, including unwitnessed cardiac arrest, and seizures of unknown etiology.
Side Effects- this solution is very neurotoxic should it extravasate into tissue. Aspirate frequently to insure blood return.
Note-A blood glucose should be obtained prior to and 20 minutes after administration of Dextrose.
Typical Preparations- 25Gm (50%) in 50ml and 2.5gm (25%) in 10ml
Dose: Adult: 50ml rapid IV/IO push. May repeat after re-checking blood sugar.
Pediatric: 0.5gm/kg of 50% Dextrose IV/IO, dilute with equal amount NS or 25% Dextrose
Infants: 0.5gm/kg of 25% Dextrose IV/IO

DIPHENHYDRAMINE- Antihistamine- Administered after Epinephrine in the treatment of anaphylaxis, used to inhibit histamine release in allergic reactions. Histamine release causes capillary dilation and increased capillary permeability, both of which lead to edema formation. Benadryl is also useful in the treatment of extrapyramidal reactions. Will cause marked improvement, if not total resolution of those symptoms.
Side Effects- Drowsiness, dizziness, sedation, disturbed coordination. Dry mouth, may aggravate glaucoma, and cause urinary retention. Alcohol, narcotics, CNS depressants or other antihistamines may enhance the sedative effects of Benadryl.
Typical Preparations- 1cc (50mg/1ml) ampule or vial
Dose: Adult: 50mg IM or 25mg IV slowly
Pediatric: 2mg/kg IM or 1mg/kg IV slowly

DOPAMINE- Sympathetic agonist- A naturally occurring catecholamine and a chemical precursor of norepinephrine. It acts on alpha receptors, is dose dependent, causing peripheral vasoconstriction. The effect on beta 1 receptors causes a positive inotropic effect on the heart, without increasing myocardial oxygen demand as much as Epinephrine. Because of its effects on dopamine receptors when used in therapeutic doses, it maintains renal and mesenteric blood flow. Used in cardiogenic shock, or in patients with significant hypotension, when fluid replacement is unsuccessful. May also be useful in severe CHF or acute allergic reaction.
Side Effects- Increased heart rate. Can worsen or induce narrow complex and wide complex tachycardias. With narrow complex or wide complex tachycardias do not administer. Deactivated by alkaline solutions such as Sodium Bicarbonate. May cause hypotension in patients taking Dilantin.
Typical Preparations- 200mg/5ml: ampule or vial
Dose: Adult: 5-20mcg/kg/min. For the average adult 400mg of Dopamine in 250ml D5W at a rate of 30-60 microdrops/minute provides this dose range. Titrate to blood pressure and other signs of perfusion
Pediatric: **Contraindicated** in children under 8 years of age within the ICEMA region

EPINEPHRINE- Endogenous catecholamine- Epinephrine is an adrenergic agent with both alpha and beta receptor stimulating actions; effects include increased heart rate, contractility electrical activity, blood pressure, systemic vascular resistance and automaticity. Epinephrine initiates electrical activity in asystole and converts fine v-fib to course v-fib, thereby improving chances for successful defibrillation. In addition, it is a smooth muscle relaxant in severe reactive airway disease, and decreases bronchospasm in anaphylaxis.
Side Effects- Effects may be intensified in patients taking anti-depressants. All patients should be observed for tachy-arrhythmias. Epinephrine will precipitate if mixed with Sodium Bicarbonate.
Typical Preparations- 1ml 1:1,000 ampule, 10ml 1:10,000 syringe and 30ml 1:1000 multi-dose vial
Dose: Adult: Cardiac Arrest 1.0mg IV/ET/IO May repeat every 3-5 minutes. Maximum 3mg PTC
Pediatric: Cardiac Arrest: 1 Day to 8 Years of Age .01mg/kg IV/IO May repeat every 3 -5minutes at 0.01mg/kg Et dose is 10 times the IV dose, 0.1mg/kg diluted in 2-5ml NS, 3-5 minutes.
Post Resuscitative Care: 1 Day to 8 Years of Age: 0.005mg/kg (1:10,000) IV every 10 minutes for hypotension.
Cardiac Arrest: 9 to 15 Years of Age - Same as Adult dosage

EPINEPHRINE cont.

Adult: Acute Allergic Reaction and/or Bronchospasm: 0.3mg SC (1:1,000 solution) May repeat one time. Maximum total dosage 0.5mg for severe anaphylaxis

Pediatric: Acute Allergic Reaction and/or Bronchospasm: 0.01 mg/kg SC (1:1,000) up to 0.3mg SC Maximum total dosage 0.05 mg/kg for severe anaphylaxis

FUROSEMIDE- Diuretic- Lasix is a potent diuretic inhibiting sodium chloride re-absorption in the kidney. It also causes venous dilation. Used in the later stages of CHF and pulmonary edema to remove excess fluid. Use with extreme caution in patients who may have Pneumonia, as these patients may be dehydrated

Side Effects- Dehydration and electrolyte depletion, which may lead to digitalis and/or lithium toxicity, hypokalemia, hyponatremia, and hypoglycemia. Hypotension, EKG changes, and chest pain. Fetal abnormalities.

Typical Preparations- 10mg/ml vials.

Dose: Adult: 40-100mg IV or 2 times the daily dose. Maximum dose 100mg IV slowly. May only be given by Base Hospital order or in RCF

Pediatric: 1mg/kg IV slowly. Base Hospital Order only.

GLUCAGON- Pancreatic hormone- Elevates blood glucose level by causing a breakdown of glycogen stored in the liver to glucose. Also inhibits the synthesis of glycogen from glucose. Hypoglycemia when IV access is unobtainable. Administer with caution to patients with a history of cardiovascular or renal disease. Administer with caution to patients with history of possible esophageal foreign body aspiration

Side Effects- Nausea and vomiting. Hypersensitivity.

Typical Preparations: 1ml ampule containing 1mg Glucagon. Use only dilutent provided to make a 1mg/ml solution.

Dose: Adult: 1mg IM/SC. The onset of action is within 5 to 20 minutes. May also be given IV.

Pediatric: 0.025mg/kg, IM/SC. May repeat 1 time after 20 minutes, if the total of both doses does not exceed 1mg.

LIDOCAINE- Antidysrhythmic- With the changes recommended by AHA, there has been a change in how Lidocaine is used. For Unstable V-Tach or Wide Complex Tachycardias and VF/Pulseless VT it continues to be recommended. It suppresses the automaticity of ventricular ectopic pacemakers. During a myocardial infarction, Lidocaine elevates the ventricular fibrillation threshold. A Lidocaine bolus should be followed by a 2-4mg/min infusion to maintain therapeutic blood levels. Lidocaine is also effective when used at 1.5mg/kg as rapid IV bolus prior to intubation of a head injured patient. In this instance, it numbs the oropharynx for approx 1 minute, thereby decreasing the chance of increasing the ICP during intubation.

Side Effects- Contraindicated in 2nd degree Type II, and 3rd degree AV blocks. As it may further slow the conduction of the electrical impulse from the atria to the ventricles. Lidocaine should never be given in conjunction with premature ventricular contractions and bradycardic rhythms. In these cases the bradycardic rhythm should be treated first. CNS depression may occur at high doses. In addition, use decreased dosages for elderly patients and those with impaired liver and renal function. Symptoms of CNS depression may include: decreased level of consciousness, irritability, confusion, muscle-twitching, seizures, coma and finally, death.

Typical Preparations- 5ml preload syringes (100mg/5cc)
250ml NS with IGM Lidocaine premixed.

Dose: Adult: VF/Pulseless VT and unstable VT or Wide Complex Tach 1mg/kg slow IV push. Repeat at one half the initial dose every 5-10 minutes to a maximum of 3mg/kg
Maintenance dose: 1-4mg/min

Pediatric: Cardiac Arrest 1 Day to 8 Years of Age: 1.0mg/kg IV/IO.

Cardiac Arrest: 9 to 15 Years of Age - Same as Adult dosage

MAGNESIUM SULFATE- Magnesium supplement and anticonvulsant- One of the major cations and an essential element in numerous biochemical reactions in the body. Responsible for neurotransmission and muscular excitability. Low levels of magnesium may cause refractory ventricular fibrillation and impede the replenishment of intracellular potassium. Dysrhythmias associated with hypomagnesemia include: Torsade de points, refractory v-fib/v-tach, PEA and Asystole. It also acts as a peripheral vasodilator, and resolves seizures associated with toxemia of pregnancy (eclampsia).

Side Effects- May cause drowsiness, respiratory depression, hypotension and circulatory collapse. Use with caution in patients with decreased renal function, those undergoing dialysis, taking cardiac glycosides, history of hypocalcemia, and individuals in 3rd degree heart block. **NOTE-** An overdose of Magnesium may cause respiratory depression and heart block. A 10% Calcium Chloride bolus of 500mg-1gm should be given with Base Hospital order.

Typical Preparations- 10gm vial of a 10% solution

MAGNESIUM SULFATE Cont.
Dose: Adult: Seizure activity in the toxemic patient: 4gms IV/IO **slowly** diluted with 20 ml NS over 3-4 minutes
Maintenance dose: 2gms in 100ml NS at 30ml/hr
Stable VT/Wide Complex Tachycardias, PEA and Asystole: 2gm IV slowly over 3 minutes. Diluted with 20-30ml of NS
Pediatric: Not recommended in the pre-hospital setting

MIDAZOLAM- Sedative/ hypnotic – Midazolam is a short acting benzodiazepine with amnesic properties. In the pre-hospital setting, benzodiazepines are primarily used as skeletal muscle relaxants, for pre-procedure sedation, and for anticonvulsant activity. Benzodiazepines are absorbed from the GI tract and metabolized in the liver. Onset of action when administered IV is 1 to 5 minutes and less than 15 minutes when administered intramuscularly. Like other benzodiazepines, it has no effect on pain.
Side Effects – Can cause laryngospasm, bronchospasm, dyspnea, respiratory depression and arrest, bradycardia, tachycardia, PVCs and retching. Drug should not be given to patients with a history of narrow-angle glaucoma, in shock, depressed vital signs, in an alcoholic coma, or with known sensitivity to the drug, or allergies to cherries (for oral preparations only). ALWAYS monitor and document respirations when giving this drug
Typical Preparations- 2mg/2ml, 10mg/2ml and 5mg/5ml vials
Dose: Adult: Cardioversion and TCP: 1 to 2mg Slow IV push. May be given PTC to awake patients.
Seizures: 5-10mg IM or 2.5-5mg IV/IO
Pediatric: Seizures: 0.2mg/kg IM with maximum IM dose 10mg or 0.1mg/kg IV/IO, maximum IV/IO dose 2.5-5mg

MORPHINE SULFATE- Narcotic analgesic- a potent CNS depressant that reduces discomfort, apprehension and fear, in patients experiencing pain. It also has certain hemodynamic properties such as decreased systemic vascular resistance which can lead to decreased myocardial oxygen demands. Used for the severe pain associated with myocardial ischemia and/or myocardial infarct not relieved by Nitroglycerin. Used for severe pain associated with isolated extremity fractures.
Side Effects- Respiratory depression, hypotension. nausea & vomiting. Not recommended for use in the initial acute stages of CHF and PE because of the potential for respiratory compromise. Do no use in situations where the close monitoring of mental status is required (as in, head injury, multiple system trauma, hypovolemia, abdominal pain and chest trauma.) **Note-** Narcotic effects are reversible with Naloxone (Narcan.) Hypotensive effects are NOT reversible.
Typical Preparations- 1cc ampule (10mg/ml)
Dose: Adult: Suspected Acute MI: 2mg IV may repeat every 3 minutes to total 10mg
Adult Trauma: For Extremity Trauma and Suspected Hip Fracture 2mg increments up to 20mg. For burns 2-4mg increments titrated up to 30mg IV
Cold Related Emergencies: For frostbite, 2mg IV not to exceed 2mg increments to a total of 10mg or 10mg IM may repeat dosage one time for pain relief. In RCF may administer a repeat dose.
Pediatric: Pediatric Trauma: 0.1-0.2mg/kg IV not to exceed 2mg increments up to 5mg IV or 10mg IM in isolated extremity trauma or 20mg total for Burns
Cold Related Emergencies: For frostbite, 0.1mg/kg IV not to exceed 2mg increments to a total of 5mg or 0.2mg/kg IM to a total of 10mg IM titrated for pain relief. In RCF may administer a repeat dose.

NALOXONE- Narcotic antagonist- Reverses the effects of narcotics or synthetic narcotic agents by binding to central nervous system depressants. Examples of these agents are: Heroin, Methadone, Propoxyphene (Darvon), Pentazocine (Talwin), Meperidine, Morphine, Diphenoxylate (Lomotil), Codeine, Oxycodone (Percodan) and various diarrhea and cough medicines containing any of these medications.
Side Effects- In the absence of narcotics, Naloxone has no perceivable effects. Rapid reversal of narcotic overdose may lead to combative behavior. Use with caution in patients with pre-existing Cardiovascular disorders.
Typical Preparations- 2cc ampules (1mg/1ml.) 10cc Vial (4mg/10ml.) 1cc ampule/Vial (0.4mg/1ml)
Dose: Adult: 1.0-2.0mg IV, IM, or SC
Pediatric: 0.01mg/kg IV, or SC as initial dose.

NITROGLYCERINE- Smooth muscle relaxant- Rapid, direct vasodilation effect on both arterial and venous vessels causing venous pooling of blood. Also causes vasodilation of coronary arteries, thereby increasing perfusion of ischemic myocardium tissue. This action reduces myocardial work and oxygen consumption. Which leads to pain relief. In CHF and Pulmonary Edema, Nitroglycerine is used to decrease pre-load and after-load, thereby improving cardiac output. Nitroglycerin is contraindicated PTC for the patient taking Viagra and may only be given as a direct Base Hospital Physician order for these patients.
Side Effects- Hypotension. Headache. Flushing
Typical Preparations- Spray 0.4mg metered dose. Bottle 1/150gr = 0.4mg per tablet

NITROGLYCERINE Cont.

Dose: Adult: Suspected Acute MI: 1 metered dose sprayed onto the tongue (TL), or 1 tablet sublingually (SL). May repeat in 3minute intervals if signs/symptoms of adequate perfusion are present. Consider Morphine Sulfate for pain management when NTG is contraindicated (signs of inadequate tissue perfusion or recent use of sexual enhancement medications)
CHF/Pulmonary Edema: May repeat with signs/symptoms of adequate perfusion

Pediatric: Not used in children

OXYTOCIN- Hormone secreted by posterior pituitary- Causes the contraction of uterine smooth muscle and plays a role in lactation. It is effective in the pre-hospital treatment of postpartum hemorrhage by inducing uterine contractions. Before administration it is important to verify that the placenta has been delivered and there is not an additional fetus present.

Side Effects: Hypertension, cardiac dysrhythmias, and anaphylaxis have been reported as potential side effects. Therefore, it is important to monitor vital signs including BP, cardiac monitor, respiratory status and uterine tone. In addition, Oxytocin in excessive doses can cause uterine rupture. **NOTE:** Oxytocin is an optional ALS medication used during inter-facility transfers.

Typical Preparations- 10 units/1ml ampule

Dose: Adult: Inter-Facility Transport: 10-20 units in 1000ml NS. Titrate to sustain uterine contractions

PHENYLEPHRINE HYDROCHLORIDE- Direct-acting adrenergic agent, vasopressor- A synthetic sympathomimetic compound structurally similar to Epinephrine and Ephedrine. Used topically it acts locally as a potent vasoconstrictor which may reduce the chance of muscosal hemorrhage during nasal intubation.

Side Effects- Although rare, systemic absorption may lead to alpha adrenergic effects such as a transient rise in blood pressure, and/or pulse rate. Caution should be used in patients with a known history of diabetes, and/or hypertension. In addition, it may potentiate the effects of any other prescribed vasopressor agents.

Typical Preparations- 0.5% solution

Dose: Adult: 1metered dose in the affected nostril, wait 30 seconds prior to attempt at nasotracheal intubation. May be repeated once without Base Hospital contact.

PROCAINAMIDE- Antiarrhythmatic- Used in the treatment of ventricular arrhythmias by suppressing the automaticity of ectopic pacemakers, and slows interventricular conduction through the Bundle of His.

Side Effects- Hypotension, nausea, vomiting, confusion and seizures are some side effects. In addition, if hypotension, QRS segment widening by 50% of its original width, or a total dose of 17mg/kg has been given, Procainamide should be discontinued. Patients that present with pre-existing QT prolongation and/or Torsade de Pointes should not receive Procainamide. Use caution in administrating Procainamide to patients who may be experiencing an acute MI, digitalis toxicity or renal failure. Hypotension may be increased if given with other antihypertensive medications, and neurologic toxicity may be increased if administered with Lidocaine.

Typical Preparations-1gm/10ml vial.

Dose: Adult: Stable V-Tach or Wide Complex Tachycardias: Mix 1gm/250ml NS. **Give 20mg (5cc) slowly over 1 minute via IV push.** Repeat until arrhythmia is suppressed **or** to a maximum of 17mg/kg, QRS widens by 50%, or hypotension develops
Maintenance dose: 1-4mg/min if rhythm converts.
Unstable Narrow Complex and Unstable Atrial Fib/Flutter: May consider procainamide at above dosage when other interventions have been unsuccessful.

Pediatric: Not indicated in the pre-hospital setting.

SODIUM BICARBONATE- Alkalizing agent- Combines with strong acids to form a weak volatile acid that degrades to carbon dioxide and water. The end products are removed via the kidneys or lungs. Sodium Bicarbonate is used primarily late in cardiac arrest, after ventilation has been adequately addressed. Sodium Bicarbonate is also used in the treatment of Tricyclic antidepressant overdose.

Side Effects-Can cause metabolic alkalosis following overzealous administration. Do not mix Dopamine with Sodium Bicarbonate. A precipitate is formed in the presence of Calcium Chloride and Sodium Bicarbonate.

Typical Preparations- 50ml syringe (1mEq/1cc)

Dose: Adult: PEA and Asystole: 1mEq/kg IV for patient with known hyperkalemia, overdose of tricyclic antidepressant, or to alkalinize the urine in drug overdoses by Base Hospital Order

Pediatric: Use restricted to direct Base Hospital Physician order *only*.

VERAPAMIL- Slow channel calcium blocker- Slows AV conduction and prolongs the refractoriness of the AV node. Verapamil inhibits dyshrythmias caused by a re-entry mechanism (PSVT). It decreases the rapid ventricular response seen in Atrial Flutter and Atrial Fibrillation, decreases myocardial oxygen demand, and causes coronary artery and peripheral venous vasodilation. However, Verapamil is considered a second line drug to Adenosine in the treatment of narrow-complex tachydysrhythmias.

Side Effects- Systemic hypotension is the main side effect of Verapamil. In addition, it should not be administered to any patient exhibiting symptoms of severe hypotension, cardiogenic shock, pulmonary edema, patients in ventricular tachycardia, receiving intravenous beta blockers, or diagnosed with Wolff-Parkinson-White syndrome.

Typical Preparations- 2ml ampules (2.5mg/ml)

Dose: Adult: Stable Narrow Complex Tachycardias: 5mg IV over 3 minutes

Unstable Atrial Fib/Flutter with narrow complex rhythm: 5mg IV over 3 minutes. May repeat in 15 minutes at 10mg IV over 10 minutes.

Pediatric: Not indicated in pre-hospital setting at this time.

APPROVED: _____

ICEMA Medical Director Date

EXTERNAL JUGULAR VEIN ACCESS

FIELD ASSESSMENT/TREATMENT INDICATORS

Patient condition requires IV access and other peripheral IV access attempts are unsuccessful.
Patient 15 years of age and older - Base Hospital contact not required
Patient 9 to 14 years of age - Base Hospital contact required.
Patient 8 years of age and younger - not indicated

PROCEDURE

1. Inform patient of procedure, if alert.
2. Utilize axial spinal stabilization in trauma patients. If not in axial-spinal stabilization, extend and stabilize patient's neck. Maintain axial stabilization if the need to remove C collar arises.
3. Place in trendelenberg position, or apply slight pressure at base of vein for tourniquet effect.
4. Obtain external jugular vein access with appropriately sized IV catheter.
5. Securely tape catheter with occlusive dressing in place and continue to monitor for patency.
6. Recheck site frequently for signs and symptoms of infiltration.

TRANSCUTANEOUS CARDIAC PACING

FIELD ASSESSMENT/TREATMENT INDICATORS

Symptomatic Bradycardia see Protocol Reference #6011 Adult Bradycardia
Witnessed asystole see Protocol Reference #6015 Adult Cardiac Arrest
Patient 15 years of age and older - Base Hospital contact not required
Patient 9 to 14 years of age -Base Hospital order
Patient 8 years of age and younger - not indicated

PROCEDURE IN SYMPTOMATIC BRADYCARDIA

1. Start at rate of 60 and adjust the output control starting at 0 milli amperes until capture is noted. Assess peripheral pulses and confirm correlation with paced rhythm.
2. Determine lowest threshold response by turning the output control down, until capture is lost, then turn it back up slightly until capture is noted again. Maintain the output control at this level.
3. Assess peripheral pulses and confirm correlation with paced rhythm, Reassess patient for signs of adequate perfusion
4. Any movement of patient may increase the capture threshold response; the output may have to be adjusted to compensate for loss of capture.
5. With signs of inadequate tissue perfusion, increase rate **(not to exceed 100)** and contact Base Hospital.
6. Consider Midazolam 1-2 mg slow IV push if patient is awake and alert.
7. Consider Morphine Sulfate titrate in 1-2mg increments up to 10mg for patient complaint of pain with signs of adequate tissue perfusion.
8. Contact Base Hospital to advise of patient condition

PROCEDURE IN ASYSTOLE

1. Start at maximum energy output on the pacing device.
2. Follow above procedures #2-4.
3. If pacing ineffective, contact Base Hospital and consider termination of resuscitative efforts.

DOCUMENTATION

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ORAL ENDOTRACHEAL INTUBATION - ADULT

FIELD ASSESSMENT/TREATMENT INDICATORS

Non-responsive and apneic

Agonal or failing respirations, no gag reflex

When prolonged ventilation is required and adequate ventilation cannot otherwise be achieved

Procedure may be **initially** contraindicated with suspected ALOC per Protocol Reference #5007 Altered Level of Consciousness/Seizures

PROCEDURE

1. Support ventilations with appropriate basic airway adjuncts. Use in-line cervical stabilization as needed for suspected neck injury.
2. Immediately prior to intubation, consider prophylactic Lidocaine 1.5mg/kg IV for suspected head/brain injury
3. Select appropriate cuffed tube, and pre-oxygenate. Cricoid pressure should be applied during intubation to protect against regurgitation of gastric contents.
   a. Visualize the epiglottis and vocal cords with the laryngoscope. Insert the endotracheal tube until the entire balloon is 2cm past the vocal cords. Placement efforts must stop after twenty (20) seconds for ventilation
   b. Inflate the balloon with air to the point where no air leak can be heard, listen to breath sounds and resume ventilation with 100% oxygen and secure the endotracheal tube
   c. Monitor end-tidal CO_2 and/or pulse oximetry and suction the trachea when necessary
   d. Document verification of tube placement
4. If unable to place ET after a maximum of three (3) intubation attempts and if unable to adequately ventilate patient via BVM or ETAD consider needle cricothyrotomy per protocol Reference #4030 Needle Cricothyrotomy.

DOCUMENTATION

Upon arrival at the receiving hospital, the Advanced Skills Evaluation Form on the back of the yellow copy of the O1A Form or electronic equivalent must be filled out and signed by receiving physician. This form must then be forwarded to ICEMA within one week by either the PLN at the receiving facility if it is a Base Hospital or by the EMT-P's Agency EMS/QI Coordinator.

In the event the receiving physician discovers the ET is not placed in the trachea, an Incident Report must be completed and forwarded to ICEMA within one week by the EMS/QI Coordinator/PLN.

ORAL ENDOTRACHEAL INTUBATION - PEDIATRIC
(Birth through 14 Years)

FIELD ASSESSMENT/TREATMENT INDICATORS

Non-responsive and apneic

Agonal or failing respirations, no gag reflex

Procedure may be initially contraindicated with suspected ALOC per Protocol Reference #7007 Pediatric Altered Level of Consciousness

PROCEDURE

1. Support ventilations with appropriate basic airway adjuncts. Use in-line cervical stabilization as needed for suspected head or neck injury
2. Immediately prior to intubation consider prophylactic Lidocaine 1.5mg/kg IVP for suspected head/brain injury
3. Select stylet with appropriate tube size (uncuffed tubes should be used on patients less than eight years of age), position the patient appropriately for age and pre-oxygenate
   a. Visualize the vocal cords with the laryngoscope, watch as tube passes through the vocal cords then advance tube until vocal cord marker is situated beyond vocal cords. Placement efforts must stop after twenty (20) seconds for ventilation.
   b. Listen for breath sounds, resume ventilation with 100% oxygen and secure the airway. Place all patients under the age of 8 years in full axial-spinal stabilization.
   c. Monitor end-tidal CO_2 and/or pulse oximetry during procedure
   d. Document verification of tube placement.
4. After two (2) intubation attempts, Base Hospital contact is required (an attempt is made when the tube passes the gum line).
5. If unable to adequately ventilate patient via BVM, consider Needle Cricothyrotomy per Protocol Reference #4030 if patient is at least 2 years of age.

DOCUMENTATION

Upon arrival at the receiving hospital, the Advanced Skills Evaluation Form on the back of the yellow copy of the O1A Form or electronic equivalent must be filled out and signed by receiving physician. This form must then be forwarded to ICEMA within one week by either the PLN at the receiving facility if it is a Base Hospital or by the EMT-P's Agency EMS/QI Coordinator.

In the event the receiving physician discovers the ET is not placed in the trachea, an Incident Report must be completed and forwarded to ICEMA within one week by the EMS/QI Coordinator/PLN.

TRACHEAL INSTILLATION OF MEDICATIONS

FIELD ASSESSMENT/TREATMENT INDICATORS

No peripheral vascular access readily available
ET, NT, or needle cricothyrotomy device in place

RECOMMENDED MEDICATIONS

1. Lidocaine
2. Epinephrine
3. Atropine
4. Naloxone

PROCEDURE

1. Assure and maintain airway placement
2. Pre-oxygenate 15-30 seconds with 100% O_2 via BVM
3. Discontinue CPR
4. Instill medications
   a. Patient 9 years of age and older - double the IV dose with total fluid volume not to exceed 10ml.
   b. Patient 8 years of age and younger - single the IV dose for all medications **except** Epinephrine which should be given at 0.1 mg/kg (1:1000) with total fluid volume not to exceed 2-5ml (medications + NS)
5. Re-oxygenate 15-30 seconds with 100% O_2.
6. Resume CPR
7. Re-evaluate airway placement and response to therapy

SYNCHRONIZED CARDIOVERSION

FIELD ASSESSMENT/TREATMENT INDICATORS

Unstable V-Tach or Wide Complex Tachycardias (sustained)
Unstable Narrow Complex Tachycardias
Patient 15 years of age and older - Base Hospital contact not required
Patient 9 to 14 years of age - Base Hospital order required
Patient 8 years of age and younger - not indicated

PROCEDURE

1. Monitor patient in a lead that maximizes upright R wave and minimizes T wave, and observe location of synchronized marker on the R wave.
2. Consider Midazolam 1-2 mg slow IV push for all awake patients.
3. Consider Morphine Sulfate titrated in 1-2mg increments up to 10mg for patient complaint of pain with signs of adequate tissue perfusion.
4. Select initial energy level setting at 100 joules, or a clinically equivalent biphasic energy level per manufacture guidelines.
5. Procedure may be repeated at 200, 300 & 360 joules, or a clinically equivalent biphasic energy level per manufacture guidelines.
6. If cardioversion is successful, continue to monitor and refer to appropriate corresponding protocol.
7. In Radio communication failure, or with Base Hospital order, repeated cardioversion attempts at 360 joules, or a clinically equivalent biphasic energy level per manufacture guidelines, may be attempted.
8. If ventricular fibrillation should occur during preparation or following cardioversion, immediately:
   a. Turn off synchronizer and check pulse
   b. Charge unit to 200 - 360 joules, or clinically equivalent biphasic energy level per manufacture guidelines
   c. Defibrillate per appropriate corresponding protocol
9. Document all reassessments of rhythm and pulses.

INSERTION OF NASOGASTRIC/OROGASTRIC TUBE

FIELD ASSESSMENT/TREATMENT INDICATORS

Any intubated patient where gastric distention may impede ABC's
Oral route for patients with mid-facial trauma and all patients less than six months of age

CONTRAINDICATIONS

History of esophageal strictures, varices and/or other esophageal diseases
Caustic ingestion
Significant facial or head trauma
History of bleeding disorders

PROCEDURE

1. Explain procedure then position patient in high fowlers, unless otherwise contraindicated and select appropriate size naso/orogastric tube: adults 16-15fr, adolescents 12-14fr, children 8-10fr, or infants 5-6fr.
2. Measure and mark the NG/OG tube for proper insertion length and have suction equipment readily available
   a. Nasogastric--Combined distance between the tip of the nose to the ear lobe to the xiphoid process
   b. Orogastric--Combined distance between the corner of the mouth to the ear lobe to the xiphoid process.
3. Examine both nares to determine nare with best airflow or examine oropharyngeal cavity for obstructions or secretions then:
   a. Lubricate distal third of NG tube with a water-soluble lubricant or viscous Lidocaine gel.
   b. Gently pass tube posteriorly along floor of nasal cavity.
   c. Instruct patient to swallow (if conscious).
   d. If resistance is met while using the nasal route, remove and attempt other nostril.
   e. Slowly rotate and advance tube as you insert to mark indicating desired length.
   f. If resistance is met, remove tube and re-attempt.
4. Confirm proper placement by:
   a. Aspiration of stomach contents
   b. Injection of 30-60ml of air into tube as you auscultate for the sound of air over the epigastric region
   c. Auscultate lungs while injecting air into NG tube
5. Secure tube to bridge of nose (nasogastric) or side of mouth (or gastric)
6. Attach NG tube to suction tubing and adjust to low suction or some other type of approved suction device.
7. If patient experiences respiratory distress at anytime during procedure, remove tube immediately.

DOCUMENTATION

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NEEDLE THORACOSTOMY

FIELD ASSESSMENT/TREATMENT INDICATORS

Signs and symptoms of Tension Pneumothorax may include any or all of the following:

Increasing agitation
Progressively worsening dyspnea/cyanosis
Decreased or diminished breath sounds on the affected side
Hypotension
Distended neck veins
Tracheal deviation away from the affected side

PROCEDURE

1. Explain procedure to patient:
   a. If conscious, place patient in upright position if tolerated
   b. If patient is unconscious or in axial-spinal immobilization, leave supine
2. Use an approved pre-packaged device. If unable to obtain an approved pre-packaged device:
   a. For patients > 50kg - select a 14 or 16 gauge 2 to 2 ½ inch needle and cannula
   b. For patients less than 50kg – select a 18g, 1 to 1 1/4 inch needle and cannula.
3. Prepare area with antiseptic wipes - second intercostal space, midclavicular line.
4. Insert needle perpendicular to the chest wall, at the level of the superior border of the third rib until pleura is penetrated as indicated by one or more of the following:
   a. A rush of air
   b. Ability to aspirate free air into the syringe
5. Remove syringe and needle stylet and leave cannula in place. Add flutter valve.
6. Secure needle hub in place with tape or other approved device.
7. Reassess patient lung sounds and respiratory status immediately and every five minutes.
8. Contact Base Hospital.

INTRAOSSEOUS INFUSION (IO)

FIELD ASSESSMENT/TREATMENT INDICATIONS

Primary vascular access in cardiac arrest patients 8 years of age and younger
Patient unresponsive and venous access unavailable by any other means

CONTRAINDICATIONS

Fracture of target bone
Previous IO attempt and marrow entry at target site

PROCEDURE

1. Select and prep the following preferred sites for patient age
   a. 8 Years of Age and younger - Anterior medial surface of tibia, 2cm below tibial tuberosity
   b. 9 Years of Age and older - Lower end of tibia, 2cm above the medial malleous
   c. Base Hospital Contact - Anterior distal femur, 2cm above the patella
2. Utilizing appropriate sized IO needle for age, apply downward pressure in a twisting motion perpendicular to the surface of target site. Upon entrance into medullary cavity slightly advance needle 1-2mm.
3. Confirm placement by:
   a. Needle stands upright without support
   b. Aspiration of blood/marrow or able to instill fluid bolus without s/s of extravasation
   c. Ability to infuse IV solution without s/s of extravasation
4. Leave site uncovered and attach IV extension and attach IV extension tubing with stopcock directly to IO needle, and hinge tape regular IV tubing to extremity to secure site.
5. Infusion may need to be pressurized using syringe or pressure bag device.
6. Contact Base Hospital if patient condition indicates use of Dopamine in patients 9 years of age or older.

DOCUMENTATION

Upon arrival at the receiving hospital, the Advanced Skills Evaluation Form on the back of the yellow copy of the O1A Form or electronic equivalent must be filled out and signed by the receiving physician. This form must then be forwarded to ICEMA within one week by either the PLN at the receiving facility if it is a Base Hospital or by the EMT-P's Agency EMS/QI Coordinator.

NASOTRACHEAL INTUBATION

FIELD ASSESSMENT/TREATMENT INDICATORS

Possible cervical spine injury with clenched jaw and gag reflex
Trapped and inaccessible for direct laryngoscopy
Severe respiratory distress per Protocol Reference #5001 Shortness of Breath
Patient nare able to accommodate 7.0, 7.5 or 8.0 Endotracheal Tube

RELATIVE CONTRAINDICATIONS

Base Hospital Contact Required

Significant facial trauma, trauma to the face or nose and/or possible basilar skull fracture
Anticoagulant therapy

PROCEDURE

1. Support ventilations with appropriate basic airway adjuncts, and explain the procedure to a conscious patient.
2. Immediately prior to intubation, consider prophylactic Lidocaine 1.5mg/kg IVP for suspected head/brain injury.
3. Select the nostril to be used and inspect for patency and air flow, select appropriate cuffed tube and pre-oxygenate patient with 100% oxygen prior to attempting procedure.
   a. If patient becomes apneic, discontinue procedure and attempt oral intubation.
   b. Lubricate distal tip with a water soluble jelly or viscous Lidocaine
   c. Position the patient as tolerated. Hold in-line cervical stabilization if neck injury is suspected.
   d. Administer one (1) metered dose, 0.5mg of phenylephrine HCL to selected nostril May be repeated once prior to additional attempt.
   e. With one hand, advance ET tube into selected nostril, with bevel out, while applying cricoid pressure with the other hand. Monitor breath sounds continuously while gently guiding the tube into the trachea.
   f. Inflate balloon with air and ventilate with 100% oxygen then secure tube.
   g. Verify and document tube placement.
   h. Monitor end-tidal CO_2 and/or pulse Oximetry during procedure
   i. Suction the trachea when necessary
4. Contact Base Hospital if unable to place NT after a maximum of three (3) NT intubation attempts or if unable to adequately ventilate patient via BVM.

DOCUMENTATION

Upon arrival at the receiving hospital, the Advanced Skills Evaluation Form on the back of the yellow copy of the O1A Form or electronic equivalent must be filled out and signed by receiving physician. This form must then be forwarded to ICEMA within one week by either the PLN at the receiving facility if it is a Base Hospital or by the EMT-P's Agency EMS/QI Coordinator.

In the event the receiving physician discovers the ET is not placed in the trachea, an Incident Report must be filed and forwarded to ICEMA within one week by the EMS/QI Coordinator/PLN.

NEEDLE CRICOTHYROTOMY

FIELD ASSESSMENT/TREATMENT INDICATORS

Upper airway obstruction with severe respiratory distress
Unable to ventilate utilizing conventional airway maneuvers or devices

ABSOLUTE CONTRAINDICATON

Less than 2 years of age

PROCEDURE

1. Support ventilations with appropriate basic airway adjuncts. Use in-line cervical stabilization as needed. Explain procedure to a conscious patient.
2. Assemble appropriate equipment and pre-oxygenate prior to attempting procedure.
   a. Locate the soft cricothyroid membrane between the thyroid and cricoid cartilage
   b. Insert appropriately sized needle and verify position (an approved needle cricothyroid device may be utilized per manufacture guidelines)
      i. Adult 10-15 ga needle
      ii. Pediatric 12-15 ga needle
   c. Per manufacturer's recommendation, attach cannula adapter to BVM or use Translaryngeal Jet Ventilation (TLJV) device and ventilate with either BVM or TLJV (one second on three seconds off)
   d. Assist with exhalation, if needed, by intermittently pressing downward and upward on chest wall. Consider adding a 3-way stopcock or y connector inline to facilitate exhalation
3. Document verification of needle placement
4. Monitor end-tidal CO_2 and/or pulse oximetry, and chest expansion
5. Contact Base Hospital if unable to adequately ventilate patient, and transport immediately to closest hospital for airway management.

DOCUMENTATION

Upon arrival at the receiving hospital, the Advanced Skills Evaluation Form on the back of the yellow copy of the O1A Form or electronic equivalent must be filled out and signed by receiving physician. This form must then be forwarded to ICEMA within one week by either the PLN at the receiving facility if it is a Base Hospital or by the EMT-P's Agency EMS/QI Coordinator.

VAGAL MANEUVERS

FIELD ASSESSMENT/TREATMENT INDICATORS

Stable Narrow Complex Tachycardias

RELATIVE CONTRAINDICATIONS

Hypertension
Suspected acute MI
Suspected head/brain injury

PROCEDURE

1. Explain procedure to patient.
2. Have patient perform one of the following procedures:
   a. Have the patient pinch his nostrils together, close mouth and blow against a closed glottis
   b. Have patient bear down as if having a bowel movement
   c. Have patient submerge face in ice water or apply cold wet washcloth against face (preferred method for infants)
3. All procedures should be performed until arrhythmia is terminated or for a maximum of 10 seconds.
4. Re-evaluate cardiac and hemodynamic status. Document rhythm before, during and after procedure.
5. If rhythm does not convert within 10 seconds, follow Protocol Reference #6004 Adult Tachycardias.

AXIAL SPINAL STABILIZATION

FIELD ASSESSMENT/TREATMENT INDICATORS

Any patient in which axial spinal stabilization is clinically indicated, including but not limited to:

- Mechanism of injury
- Soft tissue damage associated with trauma
- Any blunt trauma above the clavicles
- Unconscious patients where the mechanism of injury is unknown

All intubated Neonatal and Pediatric patients

BLS INTERVENTIONS

1. Apply manual axial stabilization.
2. Assess and document distal function before and after application.
3. For pediatric patients, if the level of the patient's head is greater than that of the torso, use approved pediatric spine board with a head drop or arrange padding on the board to keep the entire lower spine and pelvis in line with the cervical spine and parallel to the board.
4. For patients being placed on a board, consider providing comfort by placing padding on the backboard
5. Any elderly or other adult patient who may have a spine that is normally flexed forward, should be stabilized in their normal anatomical position.
6. When a pregnant patient is placed in axial spinal stabilization the board should be elevated at least 4inches on the left side to decrease pressure on their Inferior Vena Cava.
7. Certain patients may not tolerate normal stabilization positioning due to the location of additional injuries. These patients may require stabilization in their position of comfort. Additional materials may be utilized to properly stabilize these patients while providing for the best possible axial spinal alignment.

ALS INTERVENTIONS

ALS personnel may remove patients placed in axial spinal stabilization by First Responders and BLS personnel, if the patient does not meet **any** of the following indicators after a complete assessment and documentation on the patient care record.

1. Have cervical pain or pain to the upper 1/3 of the thoracic vertebrae. Spinal tenderness or pain, with or without movement of the head or neck, distal numbness, tingling, weakness or paralysis
2. Have altered mental status
3. Appear to be under the influence of alcohol or other drugs (even if the patient is alert and oriented)
4. Have additional sites of significant distracting pain or are experiencing emotional distress
5. Are less than 4 years of age
6. Are unable to adequately communicate with the EMS personnel due to a language barrier or other type of communication difficulty
7. Have any other condition that may reduce the patient's perception of pain

PULSE OXIMETRY

AUTHORITY
California Code of Regulations Title 22, Division 9, Chapter 2 Section 100063

PURPOSE
To identify guidelines for the use of Pulse Oximetry for those agencies approved to utilize this device

FIELD ASSESSMENT/TREATMENT INDICATORS

All patients with neurological, respiratory or cardiovascular complaints
All patients with abnormal vital signs
All patients who may have taken respiratory depressants
Trauma patients
Pulse Oximetry may be utilized on any patient

PROCEDURE

1. Remove nail polish, if necessary; utilize adhesive sensor or apply sensor to the side of the finger
2. Attach pulse ox, note that motion at the sensor site may mimic pulsatile activity
3. Allow equilibration time, note that low perfusion (shock), edema, anemia and carbon monoxide poisoning may result in an inaccurate pulse ox reading
4. Document pulse rate and pulse ox reading
5. Monitor constantly and document pulse ox at appropriate intervals

NOTE: The administration of oxygen is not determined by the Pulse Oximetry reading. High flow oxygen will be utilized as indicated by current protocols. Pulse Oximetry is used only as a guide in providing overall care to the patient. Emergency care will not be delayed while waiting for a Pulse Oximetry reading.

ESOPHAGEALTRACHEAL AIRWAY DEVICE (ETAD)

FIELD ASSESSMENT/TREATMENT INDICATORS

ETAD intubation may be performed only on those patients who meet ALL of the following criteria:

Unresponsive and apneic (<6 per minute)
No gag reflex
Over 15 years of age
LA (large adult) device – Height 5 feet tall
SA (small adult) device – Height 4ft – 5ft 6inches tall

ADDITIONAL CONSIDERATIONS

BVM management not adequate or effective
Endotracheal Intubation is unsuccessful after three attempts
An ETAD should not be removed unless there is a malfunction
Medications may NOT be given via the ETAD

CONTRAINDICATIONS

Known ingestion of caustic substances
Suspected foreign body airway obstruction (FBAO)
Facial and/or esophageal trauma
Patients with known esophageal disease (cancer, varices, surgery, etc.)

PROCEDURE

1. Support ventilations with appropriate basic airway adjuncts
2. Select appropriate ETAD size and pre-oxygenate prior to attempting procedure. If resistance is met while advancing tube, discontinue procedure.
   a. Lubricate distal end of device with water-soluble lubricant
   b. Attach right angle emesis deflector to lumen #2
   c. Perform tongue jaw lift and gently insert device in mid-line and until teeth are between the double black rings
   d. Inflate pharyngeal cuff per manufacture recommendations
   e. Inflate distal cuff per manufacture recommendations and remove syringe
   f. Attach BVM and remove syringe to lumen #1 (esophageal) and ventilate. Verify placement by:
      i. Rise and fall of the chest
      ii. Bilateral breath sounds
      iii. Absent epigastric sounds
      iv. End-tidal CO_2 detector and/or pulse oximetry
3. After tube placement has been verified, continue to ventilate through lumen #1.
   a. If breath sounds are absent and epigastric sounds are present, remove bag valve and ventilate through lumen #2 (tracheal).
   b. If unable to confirm placement, remove and continue to use a BVM with either an OPA or NPA.
4. ETAD placement may be attempted two times.

DOCUMENTATION

Upon arrival at the receiving hospital, the Advanced Skills Evaluation Form on the back of the yellow copy of the O1A Form or electronic equivalent must be filled out and signed by receiving physician. This form must then be forwarded to ICEMA by either the PLN at the receiving facility if it is a Base Hospital or by the EMT-P's Agency EMS/QI Coordinator.

In the event the receiving physician discovers the device is improperly placed, an Incident Report must be filed and forwarded to ICEMA within one week by the EMS/QI Coordinator/PLN.

Note: This skill may only be preformed by those EMT-I individuals employed by an approved ETAD provider.

ADULT RESPIRATORY EMERGENCIES

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

FIELD ASSESSMENT/TREATMENT INDICATORS

Chronic symptoms of pulmonary disease, wheezing, cough, pursed lip breathing, decreased breath sounds
Accessory muscle use, anxiety, ALOC or cyanosis

BLS INTERVENTIONS

1. Reduce anxiety, allow patient to assume position of comfort
2. Administer oxygen as clinically indicated, obtain oxygen saturation on room air, or on home O_2 if possible

ALS INTERVENTIONS

1. Maintain airway with appropriate adjuncts, obtain oxygen saturation on room air, or on home O_2 if possible
2. Place on cardiac monitor,
3. Nebulized Albuterol 2.5mg, may repeat twice.
4. Obtain vascular access.
5. Contact base hospital if no improvement

ACUTE ASTHMA/BRONCHOSPASM

FIELD ASSESSMENT/TREATMENT INDICATORS

History of prior attacks, associated with wheezing, diminished breath sounds, or cough.
A history of possible toxic inhalation, associated with wheezing, diminished breath sounds, or cough
Suspected allergic reaction associated with wheezing, diminished breath sounds or cough

BLS INTERVENTIONS

1. Reduce anxiety, allow patient to assume position of comfort
2. Administer oxygen as clinically indicated, humidified oxygen preferred

ALS INTERVENTIONS

1. Maintain airway with appropriate adjuncts, obtain oxygen saturation on room air if possible
2. Place on Cardiac monitor
3. Nebulized Albuterol 2.5mg, may repeat twice
4. Obtain vascular access, for signs of inadequate tissue perfusion initiate IV bolus of 300cc NS. If signs of inadequate tissue perfusion persist may repeat fluid bolus.
5. If no response to Albuterol, give Epinephrine 0.3mg SC. Contact Base Hospital for patients with a history of coronary artery disease, history of hypertension or over 40 years of age prior to administration of Epinephrine
6. May repeat Epinephrine 0.3mg SQ after 15 minutes

7. For suspected allergic reaction, consider Diphenhydramine 25mg IV, or 50mg IM
8. Consider advanced airway per protocol Reference #4029 Nasotracheal Intubation
9. If no improvement, Base Hospital may order repeated treatments with Nebulized Albuterol 2.5mg

ACUTE PULMONARY EDEMA/CHF

FIELD ASSESSMENT/TREATMENT INDICATORS

History of cardiac disease, including CHF, and may present with rales, occasional wheezes, jugular venous distention and/or peripheral edema

BLS INTERVENTIONS

1. Reduce anxiety, allow patient to assume position of comfort
2. Administer oxygen as clinically indicated. For pulmonary edema with high altitude as a suspected etiology, descend to a lower altitude and administer high flow oxygen with a non re-breather mask
3. Be prepared to support ventilations as clinically indicated.

ALS INTERVENTIONS

1. Maintain airway with appropriate adjuncts, Obtain oxygen saturation on room air if possible
2. Nitroglycerine 0.4mg sublingual/transmucosal with signs of adequate tissue perfusion. May be repeated as long as patient continues to have signs of adequate tissue perfusion.
3. If a Right Ventricular Infarction is suspected, the use of nitrates is contraindicated.
4. Place on cardiac monitor
5. Obtain vascular access, Saline Lock preferred
6. Consider advanced airway per protocol Reference #4029 Nasotracheal Intubation
7. Base Hospital may order MS titrated in 1-2mg increments
8. Base Hospital may order Dopamine 400mg in 250cc NS titrated between 5 – 20mcg/min to maintain adequate tissue perfusion
9. Base Hospital may order Furosemide 40mg-100mg IV or 2 times the daily dose to maximum of 100mg IV.
10. Base Hospital may order Nebulized Albuterol 2.5mg after patient condition has stabilized.
11. In Radio communication failure (RCF) the following medications may be utilized
    a. Dopamine 400mg in 250cc NS titrated between 5 – 20mcg/min to maintain adequate tissue perfusion
    b. Furosemide 40mg-100mg IV or 2 times the daily dose to maximum of 100mg IV
    c. Nebulized Albuterol 2.5mg after patient condition has stabilized

APPROVED:

_____ _____ _____

ICEMA Medical Director Date Inyo Co. Health Officer Date Mono Co. Health Officer Date

_____ _____

San Bernardino. Co Health Officer Date ICEMA Executive Director Date

SHOCK (NON-TRAUMATIC)

PRIORITIES

ABC's
Identify signs of shock
Determine need for fluid replacement
Consider early transport

FIELD ASSESSMENT/TREATMENT INDICATORS:

1. Patient exhibits signs/symptoms of shock
2. Determine mechanism of illness
3. History of GI bleeding, vomiting, diarrhea
4. Consider hypoglycemia or narcotic overdose
5. Hypothermia preventative measures

PARAMEDIC SUPPORT PRIOR TO BASE HOSPITAL CONTACT:

1. Maintain airway with appropriate adjuncts
2. Oxygen therapy as clinically indicated. Obtain oxygen saturation on room air, unless detrimental to patient condition. Be prepared to support ventilations with appropriate airway adjuncts
3. Place on Cardiac monitor
4. Place in Trendelenburg if tolerated.
5. Obtain vascular access
6. If hypotensive give fluid challenges: In the adult give 500ml IV bolus, may repeat once to sustain a B/P >90mmHg. In the pediatric patient give 20ml/kg IV bolus, may repeat once for tachycardia, change in central/peripheral pulses, limb temperature transition, altered level of consciousness
7. For B/P >90mmHg, and no respiration difficulties in adults, maintain IV rate at150ml/hour. In pediatric patients maintain IV rate at TKO

BASE HOSPITAL MAY ORDER

***1. Establish 2nd large bore IV enroute.**
***2. Dopamine infusion at 5-20mcg/kg/min if hypotension persists despite fluid administration**.

** May be done during radio communication failure*

ALTERED LEVEL OF CONSCIOUSNESS/SEIZURES

FIELD ASSESSMENT/TREATMENT INDICATORS

Patient exhibits signs/symptoms of a possible altered level of consciousness
Assess for suspected narcotic dependence, overdose, hypoglycemia, traumatic injury, shock, and alcoholism
Tonic clonic movements followed by a brief period of unconsciousness (post-ictal).
Suspect status epilepticus for frequent or extended seizures.

BLS INTERVENTIONS

1. Oxygen therapy as clinically indicated
2. Position patient as tolerated, if altered gag reflex in absence of traumatic injury, place in left lateral position
3. Place patient in axial spinal stabilization if trauma is suspected
4. If patient history includes insulin or oral hypoglycemic medications administer Glucose sublingual

ALS INTERVENTIONS

1. Obtain vascular access and place on monitor
2. Obtain blood glucose, if hypoglycemic administer
   a. Dextrose 25 Grams (50cc) IV/IO of 50% solution or,
   b. Glucagon 1mg IM/SC, if unable to establish IV, may give one time only.
   c. May repeat blood glucose then repeat Dextrose if extended transport time.
3. For tonic/clonic type seizure activity administer
   a. Midazolam 5-10mg IM or 2.5-5mg IV/IO.
   b. Repeat Midazolam for extended or recurrent seizure activity.
4. If suspected narcotic overdose administer
   a. Naloxone 2.0mg IV/IM.
   b. Repeat Naloxone 2.0mg IV/IM every 2-3 minutes if needed.
5. Assess and document response to therapy
6. Base Hospital may order additional medication dosages and fluid bolus

ADULT AIRWAY OBSTRUCTION

FIELD ASSESSMENT/TREATMENT INDICATORS

Universal sign of distress
Alteration in respiratory effort
Altered level of consciousness

BLS INTERVENTION - RESPONSIVE

1. Assess for ability to speak or cough (e.g. "Are you choking?")
2. If unable to speak, administer abdominal thrusts/Heimlich maneuver or chest thrusts for pregnant or obese patients until the obstruction is relieved or patient becomes unconscious.
3. After obstruction is relieved, reassess and maintain ABC's
4. Administer oxygen, if capable obtain O_2 saturation, per Protocol Reference #4036 Pulse Oximetry.
5. If responsive, place in position of comfort. If uninjured but unresponsive with adequate respirations and pulse, place on side in recovery position.

BLS INTERVENTION - UNRESPONSIVE

1. Position patient supine (for suspected trauma, maintain in-line axial spinal stabilization).
2. Open airway with head tilt-chin lift (for suspected trauma use jaw thrust). Remove object if visible. Assess for presence/effectiveness of respirations for no more than 10 seconds.
3. If apneic, attempt 2 ventilations with bag-valve mask. If no chest rise, reposition airway and reattempt.
4. If apneic and able to ventilate, provide 1 breath every 5 to 6 seconds.
5. If unable to ventilate, initiate CPR according to AHA 2005 guidelines and check for pulse every 2 minutes until obstruction is relieved or able to ventilate.
6. If available, place AED per Protocol Reference #6301 AED.

ALS INTERVENTION – UNRESPONSIVE

1. If apneic, and able to ventilate, establish advanced airway.
2. If obstruction persists, visualize with laryngoscope and remove visible foreign body with Magill forceps and attempt to ventilate.
3. If obstruction persists and unable to ventilate, consider Needle Cricothyrotomy per Protocol Reference #4030 Needle Cricothyrotomy.

APPROVED

ICEMA Interim Medical Director 8/28/06 Date

ICEMA Executive Director 8/28/06 Date

ADULT AIRWAY OBSTRUCTION

FIELD ASSESSMENT/TREATMENT INDICATORS

Universal sign of distress
Alteration in respiratory effort
Altered level of consciousness

BLS INTERVENTION - CONSCIOUS

1. Assess for ability to speak or cough (e.g. “Are you choking?”)
2. Administer abdominal thrusts or chest thrusts (for pregnant or obese patients) until the foreign body becomes dislodged and expelled or until patient becomes unconscious.
3. After obstruction is relieved, reassess and maintain ABC’s
4. Administer oxygen therapy as clinically indicated

BLS INTERVENTION - UNCONSCIOUS

1. Position patient in a supine position, always suspect possible spinal injury until ruled out and move patient with in-line axial stabilization, assess and evaluate for possible mechanism of trauma
2. Open airway with tongue-jaw lift, followed by finger sweep to remove object, then assess for presence and/or effectiveness of respiration
3. If apneic, attempt bag-valve mask ventilation, if unable to ventilate, reposition airway and reattempt B.V.M. ventilation
4. If unable to ventilate, perform up to 5 abdominal thrusts, and re-attempt BVM ventilation, may repeat steps 2-4 until effective or patient becomes unconscious

ALS INTERVENTION – UNCONSCIOUS

1. If obstruction persists, after BLS interventions, visualize airway with laryngoscope and remove visible foreign body with Magill forceps
2. Attempt to ventilate, if obstruction persists despite BLS interventions perform needle Cricothyrotomy
3. Once an airway has been established ventilate and assess lung sounds

HEAT RELATED EMERGENCIES

MINOR HEAT ILLNESS SYNDROMES

FIELD ASSESSMENT/ TREATMENT INDICATORS

Environmental conditions
Postural hypotension
Dehydration
Heat cramps

BLS INTERVENTIONS

1. Remove from heat source, begin cooling measures and position with legs elevated
2. Oxygen as clinically indicated
3. Re-hydrate with small amounts of appropriate liquids as tolerated.
4. Axial-spinal stabilization if indicated

HEAT EXHAUSTION

FIELD ASSESSMENT/ TREATMENT INDICATORS

Dehydration
May have elevated temperature, vomiting, hypotension, diaphoresis, tachycardia and tachypnea
No change in LOC

BLS INTEVENTIONS

1. Remove from heat source and begin cooling measures and position with feet elevated
2. Oxygen as clinically indicated
3. Re-hydrate with small amounts of appropriate liquids as tolerated.
4. Axial-spinal stabilization if indicated

ALS INTERVENTIONS

1. Obtain vascular access
   a. Adult: Fluid bolus with 300cc NS. Reassess and repeat fluid bolus if BP remains <90mmHg.
   b. Peds < 9 years of age: Initial 20cc/kg IV/IO bolus, may repeat until palpable pulse obtained
2. Obtain blood glucose and provide treatment as clinically indicated
3. Base Hospital may order additional medication dosages and additional fluid boluses

HEAT STROKE

FIELD ASSESSMENT/ TREATMENT INDICATORS

Hyperthermia
ALOC or other signs of Central Nervous System Dysfunction
Absence or Presence of Sweating
Tachycardia, Hypotension

BLS INTERVENTIONS

1. Remove from heat source, begin cooling measures and position with legs elevated
2. Rapid cooling measures, including cold packs placed adjacent to large superficial vessels
3. Evaporative cooling measures. Avoid oral intake if patient has altered level of consciousness
4. Oxygen as clinically indicated

ALS INTERVENTIONS

1 Obtain vascular access
   a. Adult: Fluid bolus with 300cc NS. Reassess and repeat fluid bolus if BP remains <90mmHg
   b. Peds < 9 years of age: Initial 20cc/kg IV/IO bolus, may repeat until palpable pulse obtained
2. Obtain blood glucose and provide treatment as clinically indicated
3 Obtain rhythm strip for documentation with copy to receiving hospital
4. Seizure precautions, refer to Protocol Reference #5007 Altered Level of Consciousness/Seizures or Protocol Reference #7010 Pediatric Seizure if seizures occur
5. Contact Base Hospital for destination and further treatment orders

COLD RELATED EMERGENCIES

SUSPECTED FROSTBITE

FIELD ASSESSMENT/TREATMENT INDICATORS

Areas of skin that are cold, white, and hard to touch
Pain to affected extremity

BLS INTERVENTIONS

1. Elevate extremity
2. Do not rub or otherwise attempt active re-warming
3. Separate digits and wrap in dry sterile gauze

ALS INTERVENTIONS

1. Obtain vascular access
2. For c/o pain in affected extremity,
   a. Pediatric – Morphine Sulfate 0.1 mg/kg IV not to exceed 2mg increments to a total of 5mg or Morphine Sulfate 0.2mg/kg IM to a total of 10mg IM, titrated for pain relief
   b. Adult – Morphine Sulfate 2mg IV not to exceed 2mg increments to a total of 10mg or Morphine Sulfate 10mg IM may repeat IM dosage one time for pain relief
3. Base Hospital may order additional medication doses
4. In Radio Communication Failure (RCF) the EMT-P may administer a repeat dosage of Morphine Sulfate

MILD HYPOTHERMIA

FIELD ASSESSMENT/TREATMENT INDICATORS

Decreased core temperature
Cold, pale extremities
Shivering, reduction in fine motor skills
Loss of judgment and/or altered level of consciousness or simple problem solving skills

BLS INTERVENTIONS

1. Oxygen as clinically indicated
2. Remove from cold/wet environment; remove wet clothing and dry patient
3. Insulate and apply wrapped heat packs, if available, to groin, axilla and neck. This process should not be interrupted during transport

ALS INTERVENTIONS

1. Obtain vascular access
2. Cardiac Monitor
3. Consider blood glucose determination and provide treatment as clinically indicated

SEVERE HYPOTHERMIA

FIELD ASSESSMENT/TREATMENT INDICATORS

Severe cold exposure or any prolonged exposure to ambient temperatures below 36 degrees with the following indications:
Altered LOC with associated behavior changes
Unconscious
Lethargic
Shivering is generally absent
B/P and heart sounds may be unobtainable
Minimize movement

BLS INTERVENTIONS

1. Maintain appropriate airway with oxygen as clinically indicated (warm, humidified if possible)
2. Assess carotid pulse for a minimum of 1-2 minutes, if no pulse palpable; place AED if available, per Protocol Reference #16215. If no shock advised, begin CPR
3. Insulate to prevent further heat loss
4. Gently cut away wet clothing if transport time is >30 minutes

ALS INTERVENTIONS

1. Advanced airway as clinically indicated
2. Obtain vascular access and administer fluid bolus
   a. 9 years and older: 300ml warmed NS, may repeat
   b. Birth to 8 years: 20ml/kg warmed NS, may repeat
3. Obtain rhythm strip for documentation
4. For documented VF, Pulseless V-Tach, defibrillate one time at 2j/kg or 200 joules (For agencies using bi-phasic technology, follow manufactures' guidelines)
5. For documented asystole:
   a. Begin CPR
   b. May give additional fluid bolus
6. Contact Base Hospital.

APPROVED:

MAR 0 8 2006
San Bernardino Co. Health Officer Date

3/2/06
Mono Co. Health Officer Date

2-28-06
ICEMA Medical Director Date

James Richardson MD 3/16/06
Inyo Co. Health Officer Date

Virginia Hastings 3/23/06
ICEMA Executive Director Date

POISONINGS

PRIORITIES

Assure rescue personnel safety
ABC's
Determine degree of physiological distress
Obtain vital signs, history and complete physical assessment including the substance ingested, the amount, time and route.
Bring ingested substance to hospital with patient.
Expeditious transport

FIELD ASSESSMENT/TREATMENT INDICATORS

Altered level of consciousness
Signs and symptoms of substance ingestion, inhalation, injection or surface absorption
History of substance poisoning

DEFINITIVE CARE

1. Assure and maintain ABC's
2. High flow oxygen as clinically indicated. Oxygen saturation on room air prior to oxygen administration, if available
3. Contact poison control
4. Obtain accurate history of incident:
   a. Name of product or substance
   b. Quantity ingested, duration of exposure
   c. Time elapsed since exposure
   c. Pertinent medical history, chronic illness, medical problems within the last 24 hours, medication
5. Monitor vital signs
6. Expeditious transport

SUSPECTED ACUTE MI

FIELD ASSESSMENT/TREATMENT INDICATORS

Chest Pain (Typical or Atypical)
Syncopal episode
History of previous AMI
History of heart disease
Angina
Risk Factors

BLS INTERVENTIONS

1. Recognition of signs/symptoms of suspected AMI
2. Reduce anxiety, allow patient to assume position of comfort
3. O_2 as clinically indicated
4. Obtain Oxygen saturation, if trained
5. May assist patient with self-administration of Nitroglycerin and Aspirin

ALS INTERVENTIONS

1. Obtain rhythm strip for documentation
2. Aspirin 162mg
3. Consider early vascular access
4. For patients with chest pain, signs of inadequate tissue perfusion and clear breath sounds give 300ml NS bolus, may repeat
5. **For agencies utilizing 12-Lead Technology *only:***
   a. If patient condition is critical, do not delay transport to obtain EKG
   b. Obtain 12-Lead EKG
   c. If signs of inadequate tissue perfusion, or if inferior wall infarct is suspected consider obtaining a right-chest 12-lead (V4R)
   d. If right ventricular infarct (RVI) is suspected with signs of inadequate tissue perfusion, consider 300ml NS bolus, may repeat. Early consultation with Base Hospital or receiving hospital in rural areas is recommended. (Nitrates should be avoided in the presence of suspected RVI or hypotension)
   e. With documented ST segment elevation in 2 or more contiguous leads, contact Base Hospital for destination decision while preparing patient for expeditious transport
   f. Repeat 12-Lead at regular intervals, but do not delay transport of patient
6. Nitroglycerin 0.4mg sublingual/transmucosal, may repeat in 3 minute intervals if signs of adequate tissue perfusion are present. Consider Morphine Sulfate for pain management when Nitroglycerin is contraindicated (signs of inadequate tissue perfusion or recent use of sexual enhancement medications)
7. Morphine Sulfate 2mg IV, may repeat every 3 minutes to total 10mg. Consider concurrent administration of Nitroglycerin with Morphine Sulfate if there is no pain relief from the initial Nitroglycerin administration
8. Consider establishing a saline lock enroute on same side as initial IV
9. Complete thrombolytic checklist, if time permits

10. Contact Base Hospital for further Morphine Sulfate orders
11. In Radio Communication Failure (RCF) may give up to an additional 10mg Morphine Sulfate in 2mg increments with signs of adequate tissue perfusion

APPROVED:

ICEMA Medical Director Date

MAR 0 8 2006

San Bernardino Co. Health Officer Date

3/16/06

Inyo Co. Health Officer Date

3/2/06

Mono Co. Health Officer Date

3/23/06

ICEMA Executive Director Date

ADULT TACHYCARDIAS

STABLE TACHYCARDIAS

FIELD ASSESSMENT/TREATMENT INDICATORS

Heart rate >150.
Minimal or no symptoms of poor perfusion.

BLS INTERVENTIONS

1. Recognition of heart rate >150
2. Reduce anxiety, allow patient to assume position of comfort
3. Administer oxygen as clinically indicated
4. Consider transport to closest hospital or ALS intercept

ALS INTERVENTIONS

Determine cardiac rhythm, establish vascular access, if indicated, and proceed to appropriate intervention

Narrow Complex Tachycardias

1. Valsalva/vagal maneuvers
2. Adenosine 6mg rapid IV push, followed by 20cc NS, may repeat x2 at 12mg followed by 20ml NS, if no conversion
3. Consider Verapamil 5mg slowly IV over 3 minutes
4. If arrhythmia is unresolved, go to unstable interventions

V-Tach or Wide Complex Tachycardias (Intermittent or Sustained)

1. Procainamide 20mg/min IV, may repeat until arrhythmia suppressed, symptomatic hypotension, QRS widens by >50% or maximum dose of 17mg/kg given. If arrhythmia suppressed, begin infusion of 2mg/min.
2. If Procainamide administration is contraindicated, consider Lidocaine 1mg/kg slow IV may repeat @ 0.5mg/kg every 10 minutes until maximum dose of 3mg/kg given and initiate infusion of 2mg/min.
3. Magnesium 2gms in 100ml NS infuse over 5 minutes for Torsades de Pointe
4. Consider Adenosine administration, if arrhythmia is suspected to be of supraventricular origin
5. If arrhythmia is unresolved, go to unstable interventions

Atrial Fib/Flutter

1. Transport to appropriate facility
2. If condition deteriorates, go to unstable interventions

UNSTABLE TACHYCARDIAS

FIELD ASSESSMENT/TREATMENT INDICATORS:

Heart rate >150
Signs and symptoms of poor perfusion

BLS INTERVENTIONS

1. Recognition of heart rate >150
2. Reduce anxiety, allow patient to assume position of comfort
3. Administer oxygen as clinically indicated
4. Consider transport to closest hospital or ALS intercept

ALS INTERVENTIONS

1. Determine cardiac rhythm and proceed to appropriate intervention
2. Initiate NS bolus of 300ml IV

Narrow Complex

1. Synchronized Cardioversion; refer to Protocol Reference #4019
2. Adenosine 6mg rapid IV push, followed by 20cc NS, may repeat x2 at 12mg followed by 20cc NS, if no conversion
3. Procainamide 20mg/min IV, may repeat until arrhythmia suppressed, symptomatic hypotension, QRS widens by >50% or maximum dose of 17mg/kg given. If arrhythmia suppressed, begin infusion of 2mg/min.
4. Contact Base Hospital

V-Tach or Wide Complex Tachycardias (sustained)

1. Precordial thump for witnessed spontaneous Ventricular Tachycardia
2. Synchronized Cardioversion; refer to Protocol Reference #4019
3. If arrhythmia suppressed, or Cardioversion unsuccessful, administer Lidocaine 1mg/kg slow IV, may repeat @ 0.5mg/kg every 10 minutes until maximum dose of 3mg/kg is given, then initiate infusion at 2mg/min.
4. Contact Base Hospital

Atrial Fib/Flutter

1. Synchronized Cardioversion; refer to Protocol Reference #4019
2. For Narrow Complex rhythm only, give Verapamil 5mg slow IV over 3 minutes. May repeat in 15 minutes at 10mg slow IV over 3 minutes
3. Procainamide 20mg/min IV, may repeat until arrhythmia suppressed, symptomatic hypotension, QRS widens by >50% or maximum dose of 17mg/kg given. If arrhythmia suppressed, begin infusion of 2mg/min.
4. Contact Base Hospital

APPROVED:

MAR 0 8 2006
San Bernardino Co. Health Officer Date

3/2/06
Mono Co. Health Officer Date

2-28-06
ICEMA Medical Director Date

James Richardson MD 3/16/06
Inyo Co. Health Officer Date

Virginia Hastings 3/23/06
ICEMA Executive Director Date

NON-TRAUMATIC HYPERTENSIVE CRISIS

FIELD ASSESSMENT/TREATMENT INDICATORS

Headache, blurred vision
Neurological deficit
Altered level of consciousness
Chest pain, dyspnea
Pulmonary edema
Abrupt elevation of diastolic BP

CONTRAINDICATION

Nitroglycerin is contraindicated for use in a hypertensive crisis of unknown etiology

BLS INTERVENTIONS

1. Reduce anxiety, allow patient to assume position of comfort and elevate head slightly
2. Administer Oxygen as clinically indicated; prepare to assist respirations if comatose
3. Consider transport to closest hospital or ALS intercept

ALS INTERVENTIONS

1. Maintain airway with appropriate adjuncts
2. Obtain oxygen saturation on room air if possible, unless detrimental to patient condition.
3. Place on cardiac monitor and obtain rhythm strip for documentation. Copy to receiving hospital
4. Obtain vascular access, saline lock preferred.
5. Contact base hospital

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3/2/06
Mono Co. Health Officer Date

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James Richardson MD 3/16/06
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Virginia Hastings 3/23/06
ICEMA Executive Director Date

ADULT BRADYCARDIAS

ASYMPTOMATIC BRADYCARDIA

FIELD ASSESSMENT/TREATMENT INDICATORS

Heart rate < 60
Signs of adequate tissue perfusion

BLS INTERVENTIONS

1. Recognition of heart rate <60
2. Reduce anxiety, allow patient to assume position of comfort
3. Administer oxygen as clinically indicated

ALS INTERVENTIONS

1. Establish vascular access if indicated. If lung sounds clear, consider Bolus of 300cc NS, may repeat
2. Obtain oxygen saturation
3. Place on cardiac monitor and obtain rhythm strip for documentation with copy to receiving hospital

SYMPTOMATIC BRADYCARDIA

FIELD ASSESSMENT/TREATMENT INDICATORS:

Signs of inadequate tissue perfusion/shock

BLS INTERVENTIONS

1. Recognition of heart rate <60
2. Reduce anxiety, allow patient to assume position of comfort
3. Administer oxygen as clinically indicated

ALS INTERVENTIONS

1. Consider advanced airway, as indicated, and obtain Pulse Ox
2. Administer IV bolus of 300cc. Maintain IV rate at 300cc/hr if lungs remain clear to auscultation
3. Place on Cardiac monitor, and obtain rhythm strip for documentation. Copy to go to receiving hospital
4. Administer Atropine 0.5mg IVP. May repeat every 5 minutes up to a maximum of 3mg or 0.04mg/kg.
5. **Consider TCP**, per Protocol Reference # 4005, instead of Atropine for documented MI, 3rd degree AV Block with wide complex, and 2nd degree Type II AV Block
6. Attempt transcutaneous cardiac pacing of a Bradycardia rhythm with continued symptoms of inadequate tissue perfusion
7. Consider Dopamine 400mg in 250 cc of NS to infuse at 5-20 mcg/ kg/min, titrated to sustain a systolic B/P>90mmHg, and signs of inadequate tissue perfusion/shock
8. Contact Base Hospital

APPROVED:

ICEMA Medical Director Date

MAR 8 2006

San Bernardino Co. Health Officer Date

Inyo Co. Health Officer Date

Mono Co. Health Officer Date

ICEMA Executive Director Date

ADULT CARDIAC ARREST

FIELD ASSESSMENT/TREATMENT INDICATORS

Non-traumatic setting

BLS INTERVENTIONS

1. Assess patient, maintain appropriate airway, begin CPR according to AHA 2005 Guidelines
   a. Ventilation rate shall NOT exceed 12/min
   b. Ventilatory volumes shall be the minimum necessary to cause chest rise.
2. If available, place AED and follow Protocol Reference #6301 AED. CPR is **not** to be interrupted except briefly for rhythm assessment.

ALS INTERVENTIONS

1 Initiate CPR for 2 minutes if no CPR in progress and response time over 5 minutes

2. Establish advanced airway with minimal interruption to CPR After advanced airway established, compressions would then be continued at 100 per minute without pauses during ventilations.
3. Determine cardiac rhythm, proceed to appropriate intervention

Ventricular Fibrillation/Pulseless Ventricular Tachycardia

1. Defibrillate at 200 joules (or biphasic equivalent per manufacture).
2. Perform CPR for 2 minutes.
3. Administer Epinephrine 1.0mg IV/IO; repeat every 5 minutes.
4. Reassess rhythm, if VF/VT persists defibrillate at 300 joules (or biphasic equivalent per manufacture).
5. Perform CPR for 2 minutes.
6. Reassess rhythm, if VF/VT persists defibrillate at 360 joules (or biphasic equivalent per manufacture).
7. Perform CPR for 2 minutes.
8. For documented Torsades de Pointe, administer Magnesium Sulfate 2gms in 100ml NS over 5 minutes IV/IO.
9. Administer Lidocaine 1mg/kg IV/IO. May repeat at 0.5mg/min every 5 minutes to maximum dose of 3.0mg/kg.

Pulseless Electrical Activity (PEA) or Asystole

1. Assess for reversible causes and initiate treatment
2. Continue CPR with evaluation of rhythm every 2 minutes
3. Administer fluid bolus of 300cc NS IV, may repeat.
4. Administer Epinephrine 1.0mg IV/IO; repeat every 5 minutes.
5. Administer Atropine 1.0mg IV/IO; repeat every 5 minutes, maximum 3.0mg (for asystole or PEA rate <60).
6. Consider termination of efforts if patient remains in PEA, asystole (confirm in two leads), or other agonal rhythm after successful intubation and initial medications without a reversible cause identified.

Utilize the following treatment modalities while managing the cardiac arrest patient:

- If unable to establish IV/IO, medications may be administered via ET per protocol Reference #4013 Tracheal Instillation of Medications.
- Obtain blood glucose, if indicated administer Dextrose 50% 25gms IV
- Insert NG/OG Tube to relieve gastric distension per Protocol Reference #4021 Insertion of NG/OG Tube.
- Naloxone 2.0mg IV/IO for suspected opiate overdose

NOTE

1. For continued signs of inadequate tissue perfusion after successful resuscitation a Dopamine infusion of 400mg in 250ml of NS may be initiated at 5-20 mcg/kg/min IV to maintain signs of adequate tissue perfusion.
2. Base hospital physician may order additional medications or interventions as indicated by patient condition.
3. Base hospital contact is required to terminate resuscitative measures. A copy of the EKG should be attached to the PCR for documentation purposes.

APPROVED

ICEMA Interim Medical Director 8/28/06 Date

ICEMA Executive Director 8/28/06 Date

AUTOMATIC EXTERNAL DEFIBRILLATION (AED)

PURPOSE

To identify guidelines for the use of the AED for all patients 1 year of age or older, in cardiac arrest. The overall goal of the AED program is to provide for rapid defibrillation and transfer of patients to care of an ALS provider as quickly as possible.

FIELD ASSESSMENT/TREATMENT INDICATORS

All of the following criteria must be met prior to applying the AED machine:

Unresponsive, apneic, and pulseless (agonal respirations of <6 per minute)

One year of age or older

Have an apparent body temperature > 86 degrees F

If patient meets the criteria per Protocol Reference #14007 Determination of Death or Protocol Reference #14007 Withholding Resuscitation, AED application is not indicated.

PROCEDURE

1. Initiate CPR for 2 minutes if time from arrest is over 5 minutes.
2. CPR is **not** to be interrupted except briefly for rhythm assessment. (For children between 1 and 9 years of age pediatric pads are to be used according to manufacture guidelines, if available. If not using pediatric pads follow all manufacture guidelines for use on the pediatric patient).
3. Check rhythm.
   a. If shocks are required, each shock should be immediately followed by 2 minutes of CPR.
   b. If additional shocks are not required:
      i. If patient begins to move, maintain appropriate airway and oxygenation, obtain and monitor vitals signs throughout care.
      ii. If patient remains unresponsive, apneic and pulseless, continue CPR for 2 minutes and reassess.
4. Continue care as indicated by patient condition until ALS providers assume care or patient starts to move.
5. BLS agencies may **only** transfer care to a provider of equal or greater level. If a BLS transport agency is not an approved AED service provider, the AED personnel must accompany the patient with the appropriate equipment.

DOCUMENTATION AND QUALITY IMPROVEMENT

1. For BLS agencies an ICEMA approved patient care report form and data collection device shall be completed per Protocol Reference # 14012 Requirements for the Initiation, Completion, Review and Retention of Records.
2. For PS-D agencies, documentation must be made on approved form.
3. Use of the AED shall be evaluated by the provider agency through their QIP plan and all data will be used to compile the annual report to ICEMA.

Special Note

AED Units should be programmed to the latest 2005 AHA Guidelines for CPR and Emergency Cardiac Care standards for defibrillation for adults and pediatrics, no later than 06/30/2007. Until personnel and equipment have been updated to the new guidelines, agencies should continue to perform CPR as trained and follow the AED prompts as directed.

APPROVED

8/28/16
ICEMA Interim Medical Director Date

8/28/16
ICEMA Executive Director Date

PEDIATRIC CARDIAC ARREST
(1 day to 14 Years of Age)

FIELD ASSESSMENT/TREATMENT INDICATORS

Non-traumatic setting

Consider the potential causes of arrest for age

BLS INTERVENTIONS

1. Assess patient, maintain appropriate airway, begin CPR according to AHA 2005 Guidelines
   a. Ventilate at rate of 12 to 20 per minute. Ventilatory rate will decrease as patient age increases.
   b. Ventilatory volumes shall be the minimum necessary to cause chest rise.
2. If patient 1 year of age or older, utilize AED per Protocol Reference #6301 AED

ALS INTERVENTIONS

1. Initiate CPR for 2 minutes if no CPR in progress and response time over 5 minutes.
2. Establish advanced airway with minimal interruption to CPR. After advanced airway established, compressions will be continued at 100 per minute without pauses during ventilations.
   a. Endotracheal Intubation; Protocol Reference #4011 Oral Endotracheal Intubation - Pediatric
   b. Needle Cricothyrotomy; Protocol Reference #4030 Needle Cricothyrotomy
3. Determine cardiac rhythm, proceed to appropriate intervention:

Ventricular Fibrillation/Pulseless Ventricular Tachycardia

1. Defibrillate at 2j/kg, do not exceed 200joules (or biphasic equivalent)
2. Perform CPR for 2 minutes
3. Administer Epinephrine, repeat same dose every 5 minutes.
   a. 1 day to 8 years: 0.01mg/kg, (do not exceed adult dosage)
   b. 9 to 14 years: 1.0mg
   c. ET (1:1000) 0.1mg/kg (do not exceed adult dosage)
4. Reassess rhythm – If VF/VT persists defibrillate at 4j/kg, do not exceed 300 joules (or biphasic equivalent)
5. Perform CPR for 2 minutes
6. Reassess rhythm – If VF/VT persists for 3rd and subsequent shocks defibrillate at 4j/kg, do not exceed 360 joules (or biphasic equivalent)
7. Perform CPR for 2 minutes
8. Consider Lidocaine, may repeat at 0.5mg/kg after 5 minutes up to total of 3mg/kg
   a. 1 day to 8 years: 1mg/kg IO/IV/ET
   b. 9 to 14 years: 1mg/kg IV/IO. 2mg/kg ET
9. Reassess rhythm

Pulseless Electrical Activity/Asystole

1. Assess for reversible causes and initiate treatment
2. Continue CPR with evaluation of rhythm every 2 minutes

3. Administer Epinephrine, repeat same dose every 5 minutes to a maximum dose of 3.0mg IV/IO (1:10,000)
   a. Birth to 8 years: 0.01mg/kg, (do not exceed adult dosage)
   b. 9 to 14 years: 1.0mg
   c. ET (1:1000) 0.1mg/kg (do not exceed adult dosage)
4. For patients 9 to 14 years Atropine1.0mg may be given every 3 minutes, to maximum of 3mg.
5. Consider termination of efforts if patient remains in asystole or PEA after successful intubation and initial medications without a reversible cause identified.

Utilize the following treatment modalities while managing the pediatric cardiac arrest patient

- Vascular access
  1 day to 8 years: IO preferred per Protocol Reference #4026 Intraosseous Infusion
  9 to 14 years: IV/IO
  If unable to obtain vascular access, medications may be administered via ET per protocol Reference #4013 Tracheal Instillation of Medications.
  May initiate second IV/IO if indicated
- Administer fluid bolus, may repeat twice for continued signs of inadequate tissue perfusion
  1 day to 8 years: 20ml/kg NS and evaluate
  9 to 14 years: 300ml NS and evaluate
  In RCF may give 2 additional fluid boluses if indicated
- Obtain blood glucose, if indicated administer Dextrose according to Protocol Reference #7007 Pediatric Altered Level of Consciousness
- Insert Naso/Orogastric tube per Protocol Reference #4021 Insertion of Nasogastric/Orogastric Tube
- Naloxone for suspected opiate overdose, may repeat once as clinically indicated
  1 day to 8 years: 0.1 mg/kg IO/IV. Do not exceed adult dosage.
  9 to 14 years: 2mg IV/IO

NOTE

1. For continued signs of inadequate tissue perfusion **after** successful resuscitation
   1 day to 8 years: Epinephrine (1:10,000) 0.005mg/kg IO/IV every ten minutes.
   9 to 14 years: Dopamine 400mg in 250ml of NS to infuse at 5-20 mcg/kg/min IV titrated to maintain signs of adequate tissue perfusion
2. Base hospital physician may order additional medications or interventions as indicated by patient condition.
3. Base hospital contact is required to terminate resuscitative measures. A copy of the EKG should be attached to the PCR for documentation purposes.

APPROVED

ICEMA Interim Medical Director 8/28/16 Date

ICEMA Executive Director 8/28/16 Date

PEDIATRIC CARDIAC ARREST
(9 to 15 Years of Age)

FIELD ASSESSMENT/TREATMENT INDICATORS:

No spontaneous respirations or pulse
Consider the potential causes of arrest in this age group
- Drug use
- Trauma
- Congenital Abnormalities

BLS INTERVENTIONS

1. Assess environment and determine possible cause of arrest
2. Assess ABC's, initiate CPR and utilize AED if available
3. Airway management
   a. Place OPA/NPA, if available
   b. Ventilate patient with BVM and 100% supplemental oxygen

VENTRICULAR FIBRILLATION/PULSELESS VENTRICULAR TACHYCARDIA

ALS INTERVENTIONS

1. Determine dysrhythmia as pulseless V-fib/V-Tach, then defibrillate up to 3 times at 200j, 200-300j, 360j or 2j/kg, 2-4j/kg, 4j/kg (or equivalent biphasic)
2. Establish and maintain advanced airway
   a. Endotracheal intubation
   b. Needle cricothyrotomy, for patient with facial trauma or obstructed airway and unable to ventilate
3. Establish vascular access and administer 300cc NS bolus IO/IV, evaluate
4. Epinephrine (May repeat same dosage at 3-5 minute intervals)
   a. 1.0mg (1:10,000) IV/IO
   b. 2.0mg (1:1,000) via ET
5. Lidocaine 1mg/kg IO/IV/ET may repeat at 0.5mg/kg after 5 minutes. Maximum dose 3mg/kg
6. Insert naso/orogastric tube
7. If pulseless V-fib/V-Tach persists, defibrillate at 360j or 4j/kg (or equivalent biphasic) within 30-60 seconds after each medication
8. Administer additional 20ml/kg NS bolus IO/IV
9. Naloxone 2mg IO/IV/ET for suspected narcotic overdose (May repeat once as clinically indicated)

BASE HOSPITAL ORDER:

*1. Repeated boluses of 150ccNS IO/IV for suspected etiology of fluid deficit
*2. Repeated defibrillation at 360j or 4j/kg
*3. Establishment of second IO/IV

*May be done in radio communication failure

PULSELESS ELECTRICAL ACTIVITY / ASYSTOLE

ALS INTERVENTIONS

1. Determine dysrhythmia as pulseless electrical activity (PEA) or asystole.
2. Establish and maintain advanced airway
   a. Endotracheal intubation
   b. Needle cricothyrotomy, for patient with facial trauma or obstructed airway and unable to ventilate.
3. Establish vascular access IV/IO and administer 300cc NS bolus IO/IV, evaluate
4. Epinephrine (May repeat same dosage at 3-5 minute intervals)
   a. 1.0mg (1:10,000) IV/IO
   b. 2mg (1:1000) via ET
5. Atropine 1.0mg IV/ET/IO if PEA rate is slow or in asystole, (May repeat every 3 to 5 minutes to a total dose of 0.04mg/kg)
6. Administer additional 300cc NS bolus IO/IV.
7. Insert naso/orogastric tube
8. Naloxone 2mg IO/IV/ET for suspected narcotic overdose (May repeat once as clinically indicated)
9. Consider and treat identified reversible causes

BASE HOSPITAL ORDER

*1. Repeated boluses of 150cc NS IO/IV for suspected etiology of fluid deficit
*2. Establishment of second IO/IV

*May be done in radio communication failure

PEDIATRIC ALTERED LEVEL OF CONSCIOUSNESS
(Birth – 14 Years of Age)

FIELD ASSESSMENT/ TREATMENT INDICATORS

Patient exhibits inappropriate behavior for age
History or observation of an Apparent Life Threatening Event

BLS INTERVENTIONS

1. Assess environment and determine possible causes for illness
2. Axial-spinal stabilization, if clinically indicated
3. Oxygen therapy as clinically indicated
4. Airway management as indicated (OPA/NPA, BVM Ventilation)
5. Obtain core temperature, if elevated begin passive cooling measures

ALS INTERVENTIONS

1. Establish advanced airway as needed
2. Obtain vascular access and place on cardiac monitor
3. For symptomatic hypotension with poor perfusion, consider fluid bolus of 20ml/kg of NS not to exceed 300ml NS
4. Check blood glucose level
   a. For pt. < 10 kg if glucose less than 60 mg/DL
      Dextrose 25% 0.5 Gm/kg (2ml/kg) IO/IV
   b. For pt.>10 but less than 25kg if glucose less than 60mg/DL
      Dextrose 50% 0.5 Gm/kg diluted1: 1 (2ml/kg)
   c. For pt. > 25 kg if glucose less than 80mg/DL
      Dextrose 50% 0.5 Gm/kg diluted1: 1 (2ml/kg)
   d. If unable to establish IV, may give Glucagon 0.025 mg/kg IM, may be repeated 1 time after 20 minutes for a combined maximum dose of 1 mg
5. For suspected narcotic ingestion, may give Narcan 0.01 mg/kg IV/IM. Do not exceed the adult dosage of 2mg IV/IM.
6. Base Hospital may order additional medication dosages and additional fluid boluses

PEDIATRIC RESPIRATORY EMERGENCIES
(Birth to 14 Years of Age)

FIELD ASSESSMENT/TREATMENT INDICATORS

Asthma
Toxic Inhalation
Difficult Breathing
Allergic Reaction

BLS INTERVENTIONS

1. Assess environment and determine possible causes
2. Remove patient from suspected source and decontaminate as indicated
3. Recognize s/s of respiratory distress for age
4. Reduce anxiety, assist patient to assume POC
5. Oxygen administration as clinically indicated, (humidified oxygen preferred)

ALS INTERVENTIONS

1. Maintain airway with appropriate adjuncts, obtain oxygen saturation on room air if possible
2. Cardiac monitor
3. Nebulized Albuterol 2.5 mg via hand held/blow by, may repeat
4. Nebulized Albuterol 2.5 mg in 3 ml NS with Atropine 0.4 mg may be given in the third dose with Base Hospital Contact only
5. If no response to Albuterol, consider Epinephrine (1:1000) 0.01mg/kg SC not to exceed adult dosage of 0.3mg
6. Obtain vascular access at a TKO rate
7. Consider Protocol Reference #7011 Pediatric Allergic Reaction if allergic reaction suspected
8. Base Hospital may order additional medication dosages and fluid bolus

PEDIATRIC SEIZURE
(Birth – 14 Years of Age)

FIELD ASSESSMENT/TREATMENT INDICATORS

Tonic clonic movements followed by a brief period of unconsciousness (post-ictal)
Suspect status epilepticus for frequent or extended seizures
Assess for history of prior seizures, narcotic dependence, or diabetes
Assess for febrile seizures (patients under 4 years of age)
Assess for traumatic injury

BLS INTERVENTIONS

1. Protect patient from further injury, axial-spinal stabilization if indicated
2. Assure and maintain airway patency after cessation of seizure, with oxygen therapy as indicated
3. Airway management as indicated (OPA/NPA, BVM Ventilation)
4. Position patient in left lateral position in absence of traumatic injury, watch for absent gag reflex
5. Remove excess clothing and begin cooling measures if patient is febrile
6. Protect patient during transport by padding appropriately

ALS INTERVENTIONS

1. Establish advanced airway as needed
2. Obtain vascular access and place on cardiac monitor, if indicated
3. If clinically indicated, obtain a Blood Glucose level and provide treatment
4. For seizure activity administer Midazolam 0.2 mg/kg IM with maximum IM dose of 10 mg or 0.1 mg/kg IV/IO with maximum dose 2.5-5 mg IV/IO. Repeat Midazolam if necessary, not to exceed adult dosage
5. Assess and document response to therapy
6. Base Hospital may order additional medication dosages or a fluid bolus

PEDIATRIC ALLERGIC REACTION
(Birth to 14 Years of Age)

FIELD ASSESSMENT /TREATMENT INDICATORS

Signs and Symptoms of an Acute Allergic Reaction
History of Exposure to Possible Allergen

BLS INTERVENTIONS

1. Recognize s/s of respiratory distress for age
2. Reduce anxiety, assist patient to assume POC
3. Oxygen administration as clinically indicated, (humidified oxygen preferred)
4. Assist patient with self-administration of prescribed Epinephrine device
5. Assist patient with self-administration of prescribed Diphenhydramine

ALS INTERVENTIONS

1. Maintain airway with appropriate adjuncts, obtain oxygen saturation on room air if possible
2. Cardiac monitor
3. Nebulized Albuterol 2.5 mg via hand held/blow by, may repeat
4. If no response to Albuterol, consider Epinephrine (1:1000) 0.01mg/kg SC not to exceed adult dosage of 0.3mg
5. Obtain vascular access at a TKO rate.
6. For symptomatic hypotension with poor perfusion, consider fluid bolus of 20ml/kg of NS not to exceed 300ml NS and repeat as indicated.
7. Diphenhydramine 1mg/kg slow IV or 2 mg/kg IM, not to exceed adult dose of 25mg IV/IO or 50mg IM.
8. Establish additional IV access if indicated
9. For anaphylactic shock (e.g., no palpable radial pulse and a depressed level of consciousness) administer epinephrine dose 0.01mg/kg (1:10,000) IV/IO up to 0.05 mg/kg
10. Nebulized Albuterol 2.5 mg in 3 ml, NS with Atropine 0.4 mg may be given in the third dose with Base Hospital Contact only
11. Base Hospital may order additional medication dosages and additional fluid boluses

PEDIATRIC AIRWAY OBSTRUCTION
(1 Day to 14 Years of Age)

FIELD ASSESSMENT/TREATMENT INDICATORS

Universal sign of distress
Alteration in respiratory effort - drooling, grunting
Altered level of consciousness

BLS INTERVENTION-RESPONSIVE

1. Assess for ability to cry, speak or cough (e.g. "Are you choking?")
2. Administer abdominal thrusts (up to 5 back slaps and up to 5 chest thrusts for infant less than one year), until the foreign body obstruction is relieved or until patient becomes unresponsive.
3. If obstruction is relieved, reassess and maintain ABC's.
4. Administer oxygen; if approved, obtain O_2 saturation, per Protocol Reference #4036 Pulse Oximetry.
5. If responsive, place in position of comfort, enlisting help of child's caregiver if needed. If child is uninjured but unresponsive with adequate breathing and a pulse, place in recovery position.

BLS INTERVENTION-UNRESPONSIVE

1. Position patient supine (for suspected trauma maintain in-line axial stabilization). Place under-shoulder support to achieve neutral cervical spinal position if indicated.
2. Open airway, head tilt-chin lift (for suspected trauma, use jaw thrust) remove object if visible. Assess for presence/effectiveness of respirations for no more than 10 seconds.
3. If apneic, attempt 2 ventilations with bag-valve mask. Release completely, allow for exhalation between breaths. If no chest rise, reposition airway and reattempt.
4. If apneic and able to ventilate, provide 1 breath every 3 to 5 seconds. Check pulse every 2 minutes.
5. If unable to ventilate, initiate CPR according to AHA 2005 guidelines and check for pulse every 2 minutes until obstruction is relieved or able to ventilate.
6. If available, place AED per Protocol Reference #6301 AED.

ALS INTERVENTIONS

1. If apneic and able to ventilate, consider intubation per Protocol Reference #4011 Oral Endotracheal Intubation – Pediatric.
2. If obstruction persists, visualize with laryngoscope and remove visible foreign body with Magill forceps and attempt to ventilate.
3. If obstruction persists and patient older than 2 years consider Needle Cricothyrotomy per Protocol Reference #4030 Needle Cricothyrotomy.

APPROVED

ICEMA Interim Medical Director — Date 8/28/06

ICEMA Executive Director — Date 8/28/06

ADULT TRAUMA
Age 15 years and Over

If in the pre-hospital provider's judgement, the patient has been involved in a trauma incident, which because of a high-energy exchange causes the provider to be highly suspicious that the patient has the potential to be severely injured, the patient should be entered into the trauma system.

FIELD ASSESSMENT/TREATMENT INDICATORS

Refer to Protocol Reference # 8010 Adult Trauma Triage Criteria

BLS INTERVENTIONS

1. Assess environment and extrication as indicated
2. Airway management as indicated (OPA/NPA, BVM or ETAD)
3. Transport or ALS intercept to closest most appropriate facility or trauma center
4. For a Traumatic Full Arrest, an AED may be utilized per Protocol Reference #6015
5. Manage special considerations
   a. Head and Neck Trauma: Whenever possible protect an injured eye with a rigid dressing, cup or eye shield. Do not attempt to replace a partially torn globe – stabilize it in place with sterile saline soaked gauze. Cover uninjured eye.
   b. Burns: Protect the burned area
      i. Do not break blisters or remove adherent materials
      ii. Remove restrictive clothing/jewelry and cover with dry sterile dressing or sterile burn sheet
      iii. Calculate BSA and initially classify burn as Minor, Moderate or Major

ALS INDICATIONS

1. Advanced airway as indicated. (Anytime the patients airway cannot be adequately secured by field personnel, transport to the closest appropriate receiving hospital for airway stabilization and transport)
2. Vascular Access as indicated with large bore IV/IO
   a. BP<90mmHG: Initial Bolus NS IV/IO Wide Open rate until BP>90mmHg, then 300cc/hr
   b. BP>90mmHG: IV maintenance rate at 300cc/hr
3. In San Bernardino County, contact Trauma Center when the trauma triage criteria are met per protocol Reference #8010. In Inyo and Mono counties contact base hospital.
4. Manage special considerations
   a. Blunt Chest Trauma: Consider needle thoracostomy for chest trauma with symptomatic respiratory distress
   b. Isolated Extremity Trauma: For BP>90mmHg consider MS in 2 mg increments up to 20mg IV titrated to pain relief
   c. Hip Fracture: With an alert/oriented patient consider MS IV in 2 mg increments up to 20mg IV.
   d. Amputations: Document in narrative that amputated part was given to a designated staff/team member

e. Burns:
   i. If BP<90mmHg give 300cc fluid bolus may repeat.
   ii. Calculate fluid rate. Hourly rate = $\frac{(1ml) \times (wt\ in\ kg) \times (\%\ BSA)}{2}$
   iii. MS 2-4mg increments IV push up to 30mg and titrate slowly.
   iv. Nebulized Albuterol 2.5mg may repeat 3 times.

5. Base Hospital may order additional medication dosages and additional fluid boluses.

PEDIATRIC TRAUMA
Birth – 14 Years of Age

If, in the pre-hospital provider's judgement, a patient has been involved in a trauma incident, which because of the potential of a high energy exchange, causes the provider to be highly suspicious the patient has the potential to be severely injured, the patient should be entered into the trauma system

FIELD ASSESSMENT/TREATMENT INDICATORS

Refer to Protocol Reference # 8012 Pediatric Trauma Triage Criteria
Pediatric trauma assessments are based upon color, temperature, respirations and level of consciousness

BLS INTERVENTIONS

1. Assess environment with extrication as indicated
2. Airway management as indicated OPA/NPA, BVM or ETAD
3. Transport or ALS intercept to closest most appropriate facility or trauma center
4. For a Traumatic Full Arrest, an AED may be utilized per Protocol Reference #6015
5. Manage special considerations
   a. Head and Neck Trauma: Whenever possible protect an injured eye with a rigid dressing, cup or eye shield. Do not attempt to replace a partially torn globe – stabilize it in place with sterile saline soaked gauze.
   b. Amputations: Document in narrative that amputated part was given to designated staff at trauma center.
   c. Burns: Protect the burned area.
      i. Do not break blisters or remove adherent materials
      ii. Remove restrictive clothing/jewelry and cover with dry sterile dressing or sterile burn sheet
      iii. Calculate BSA and initially classify burn as Minor, Moderate or Major

ALS INTERVENTIONS

1. Advanced airway as indicated. (Anytime the patient's airway cannot be adequately secured by field personnel, transport to the closest appropriate receiving hospital for airway stabilization and transport)
2. Vascular Access as indicated with large bore IO/IV
   a. Unstable: Establish appropriate vascular access. Administer 20ml/kg NS bolus IO/IV, and evaluate for central/peripheral pulses, and/or increased level of consciousness
   b. Stable: Establish vascular access and maintain IV rate at TKO.
3. In San Bernardino County, contact Trauma Center when the trauma criteria are met per protocol Reference #8012. In Inyo and Mono counties contact Base Hospital.
4. Manage special considerations
   a. Blunt Chest Trauma: Consider needle thoracostomy for chest trauma with symptomatic respiratory distress
   b. Isolated Extremity Trauma: MS 0.1 mg/kg IV not to exceed 2 mg increments to a total of 5mg IV/IO or MS 0.2 mg/kg IM to a total of 10mg IM, titrated to pain relief.

c. Burns:
   i. Calculate fluid rate. Hourly rate = $\frac{(1ml) \times (wt\ in\ kg) \times (\%\ BSA)}{2}$
   ii. MS 0.1mg/kg titrated slowly IV/IO for pain relief (total not to exceed 20mg).
   iii. Nebulized Albuterol 2.5mg may repeat 2 times.

5. Base Hospital may order additional medication dosages, interventions and fluid boluses

ADULT TRAUMA TRIAGE CRITERIA
Age 15 and Older

Any trauma patient with one or more of the following conditions requires communication and expeditious packaging and transportation to the closest most appropriate Trauma Center: **Anytime an airway cannot be adequately secured. The patient should be transported to the closest appropriate receiving hospital for airway stabilization.** In San Bernardino County, a Trauma Base Hospital should be contacted for medical control and for destination decisions. In Inyo and Mono Counties, the assigned base hospital should be contacted.

PHYSIOLOGIC CRITERIA

1. GCS < 13
2. Systolic BP < 90mm Hg
3. Respiratory rate < 10 or > 29

ANATOMIC CRITERIA

1. Penetrating wounds to the head, neck, thorax, abdomen, pelvis, or extremities proximal to the elbow or knee including impaled objects
2. Chest injuries resulting in an unstable chest wall, flail chest or significant echymosis
3. Trauma resulting in paralysis, loss of sensation, or suspected spinal cord injury
4. Two or more proximal long bone fractures
5. Suspected pelvic fractures
6. Firm or rigid abdomen
7. Amputations
8. Isolated extremity fracture with suspected neurovascular compromise
9. Major tissue disruption
10. Traumatic burns (In San Bernardino County contact ARMC)
    a. Partial thickness burns>10% TBSA
    b. Burns that involve the face, hands, feet, genitalia perineum or major joints
    c. Third degree burn
    d. Electrical burns, including lightning injury
    e. Chemical burns
    f. Inhalation burns

MECHANISM OF INJURY CRITERIA

1. Surviving victims of any vehicular accident in which fatalities occurred in the same passenger compartment
2. High energy event - risk of severe injury
3. Falls greater than twenty (20) feet
4. Auto-pedestrian / auto-bike > 5 mph impact or patient thrown or rider run over
5. Persons ejected from any motorized vehicle
6. Patients requiring extrication greater than 20 minutes

ADDITIONAL CRITERIA

1. Any patient exhibiting one or more of the above criteria shall be called into a Trauma Center Base Hospital for medical oversight and consultation as to destination and treatment.
2. If there is a clear history of a loss of consciousness with long-term memory loss and/or vomiting and seizures and none of the above criteria are met, then contact a trauma base for physician consultation to determine appropriate patient destination.
3. Any geriatric or special needs patient who has suffered a major injury and/or where physical examination or assessment is difficult
4. If the patient is pregnant and none of the above criteria are met, then contact a trauma base for physician consultation to determine appropriate patient destination
5. In rural or wilderness areas with special circumstances, may, upon written permission from the EMS Medical Director, be exempted from specific criteria.

BURN CLASSIFICATION CHART

CLASSIFY:

MINOR

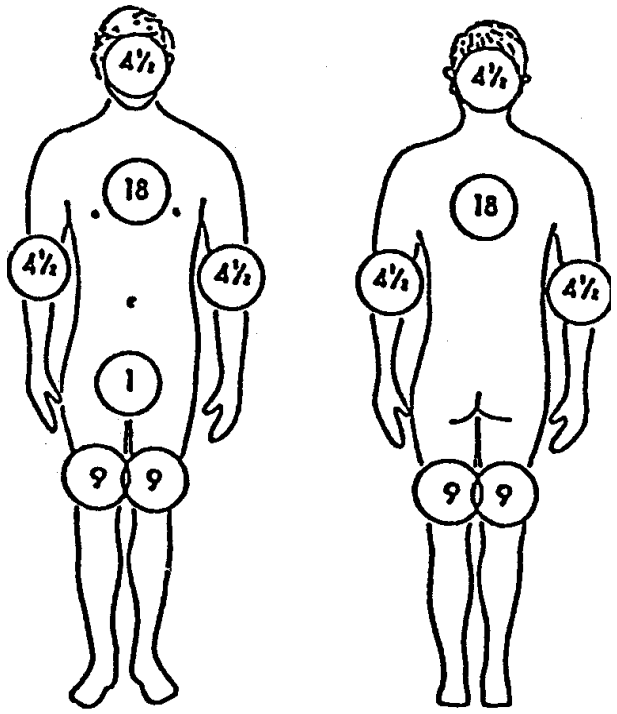
Adult ~ 15% 2nd degree
Adult ~ 2% 3rd degree

MODERATE

Adult ~ 15-25% 2nd degree
Adult ~ <10% 3rd degree

MAJOR

Adult ~ 25% 2nd degree
Adult ~ >10% 3rd degree
All electrical burns
All inhalation injuries
All burns with other associating traumas
All high risk (old age or poor health)
All burns to face, genitals, palms, or soles of feet



GLASGOW COMA SCALE OPERATIONAL DEFINITIONS

EYE OPENING

Spontaneous Eye opening is spontaneous if the patient's eyes are already open at the time of the assessment with no stimulation other than that of the existing ambient environment. The patient can close his eyes to command. This eye opening response implies an intact reticular activating mechanism and a functioning arousal mechanism.

To Voice If the patient's eyes are not open at the time of the assessment, a response to voice is present if the eyes open when the patient's name is spoken or shouted.

To Pain If verbal stimulation is unsuccessful in eliciting eye opening a response to pain is present if the eyes open when a standard pain stimulus is applied.

None No eye response is present if the above attempts at stimulation are unsuccessful

BEST VERBAL RESPONSE

Oriented After being aroused, the patient is asked name, place and date. The patient is oriented if the answers given are correct.

Confused The patient is confused if the individual cannot answer the questions regarding name, place and date accurately but is still capable of producing phrases, sentences, or conversation exchanges.

Inappropriate In this state, the patient cannot produce phrases, sentences or conversational exchanges but can produce an intact word or two. These words may be elicitable only in response to physical stimulation and may frequently be obscenities or relative's names.

Incomprehensible In this state, the patient can produce groans, moans, or unintelligible mumblings, but cannot produce an intact word in response to stimulation.

None In this state, the patient does not respond with any phonation to any stimulation no matter how prolonged or repeated

NOTE: **Tracheal or esophageal intubation renders assessment of verbal response invalid**

BEST MOTOR RESPONSE

Obedient In response to instructions, whether verbal or written, or through gestures, patient shows ability to comprehend the instruction and to physically execute it. A common example is the command to hold up two fingers.

Purposeful When a standard painful stimulus is applied, the patient may move limb or body away from stimulus in a purposeful manner or attempt to push stimulus away.

Withdrawal If the patient does not obey commands, the standard pain stimulus is applied.

Withdrawal is present if:

1. The elbow flexes,
2. The movement is rapid,
3. There is no muscle stiffness, and
4. The arm is drawn away from the trunk.

Flexion **Flexion is present if:**

1. The elbow flexes,
2. The movement is slow,
3. Muscle stiffness is present,
4. The forearm and hand are held against the body, and
5. The limbs hold a hemiplegic position.

Extension **Extension is present if:**

1. The legs and arms extend,
2. Muscle stiffness if present, and
3. External rotation of the shoulder and forearm occurs.

None Maximum standard pain stimulation produces no motor response

NOTE: **Spinal cord injury may invalidate motor assessment in this form**

PEDIATRIC TRAUMA TRIAGE CRITERIA
Birth to 14 Years of Age

Any pediatric trauma patient with one or more of the following conditions requires communication and expeditious packaging and transportation to the closest most appropriate Trauma Center: **Anytime an airway cannot be adequately secured. The patient should be transported to the closest appropriate receiving hospital for airway stabilization.** In San Bernardino County, a Trauma Base Hospital should be contacted for medical control and for destination decisions. In Inyo and Mono Counties, the assigned base hospital should be contacted.

PHYSIOLOGIC CRITERIA

1. GCS $\leq$ 13
2. Abnormal vital signs for age and weight
3. Signs and symptoms of poor perfusion

ANATOMIC CRITERIA

1. Assisted or intubated airway, airway compromise
2. Respiratory distress / multiple times suctioned
3. Penetrating wounds to the head, neck, thorax, abdomen, pelvis, or extremities proximal to the elbow or knee including impaled objects.
4. Chest injuries, suspected rib fractures or significant echymosis.
5. Trauma resulting in paralysis, suspected spinal cord injury or loss of sensation.
6. Open or 2 or more fractures
7. Isolated extremity fracture with suspected neurovascular compromise
8. Suspected pelvic fractures
9. Firm or rigid abdomen.
10. Amputations
11. Traumatic burns (In San Bernardino County contact ARMC)
    a. > 10% TBSA or involving face, airway, hands, feet or genitalia
    b. Any electrical burn
12. Altered mental status
13. Major soft tissue disruption
14. Degloving injury or flap avulsion
15. Open or depressed skull fracture

MECHANISM OF INJURY CRITERIA

1. High energy event – Risk for severe injury
2. Surviving victims of any vehicular accident in which fatalities occurred in the same passenger compartment
3. Falls greater than 3 times the child's height or greater than ten (10) feet.
4. Auto-pedestrian / auto-bike > 5 mph impact or rider/pedestrian thrown or rider/pedestrian run over.

5. Persons ejected from any motorized vehicle.
6. Patients requiring extrication greater than 20 minutes.

ADDITIONAL CRITERIA

1. Any patient exhibiting one or more of the above criteria shall be called into a Trauma Center Base Hospital for medical oversight and consultation as to destination and treatment.
2. If there is a clear history of a loss of consciousness with long-term memory loss and/or vomiting and seizures and none of the above criteria are met, then contact a trauma base for physician consultation to determine appropriate patient destination.
3. In rural or wilderness areas with special circumstances, may, upon written permission from the EMS Medical Director, be exempted from specific criteria.

BURN CLASSIFICATION CHART

MINOR

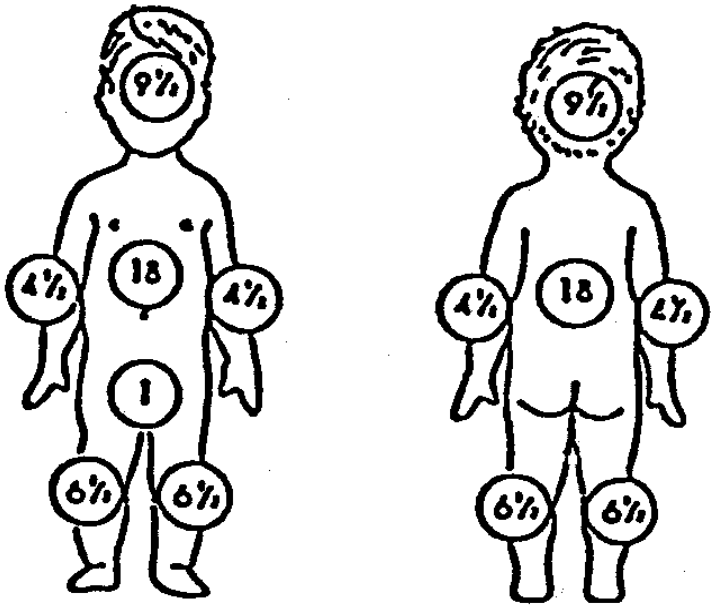
Child ~ 10% 2nd degree
Child ~ 2% 3rd degree

MODERATE

Child ~ 10-20% 2nd degree
Child ~ <10% 3rd degree

MAJOR

Child ~ 20% 2nd degree
Child ~ >10% 3rd degree
All electrical burns
All inhalation injuries
All burns with other associating traumas
All high risk (small children or poor health)
All burns to face, genitals, palms, or soles of feet



FRACTURES AND DISLOCATIONS

All EMT-I'S in the ICEMA Region will follow the policies and procedures below in the treatment of fractures and dislocations.

1. Perform a primary survey
2. Administer high flow O_2 or ventilate as necessary
3. Treat Shock
4. Secondary survey
   a. Be sure the obvious injury is the only injury
5. Check neurovascular status distal to injury
6. Protect injury from excessive movement
7. Immobilize the injury:
   a. Extremity- immobilize joint above and below injury
   b. Apply splint to injury in position found except:
      1. Femur- apply the traction splint
      2. Grossly angulated long bone fractures with distal neurovascular compromise-Apply gentle unidirectional traction to improve circulation and facilitate transport
8. Recheck neurovascular status distal to injury
9. Position of comfort unless otherwise indicated
10. Monitor vital signs
11. Transport

NOTE:

1. HAND
   a. Splint
2. LOWER ARM
   a. Splint adjacent joints
3. ELBOW
   a. Splint in position.
   b. Check circulation and neurologic status before and after splinting
4. UPPER ARM
   a. Sling and swathe
5. SHOULDER
   a. Splint in position of comfort
6. CLAVICLE
   a. Sling and swathe
7. SCAPULA
   a. Splint in position of comfort
8. RIBS
   a. Sling and swathe

9. PELVIS
    a. Place on spine board
    b. Do not roll patient
    b. Treat for shock, if presumed
    d. Splint legs together, padding under the knees for comfort
10. FEMUR
    a. Splint- traction
    b. Treat for shock if present
11. FIBULA-TIBIA
    a. Splint adjacent joints
12. HIP
    a. Splint both legs together, pillow in between, triangular bandages
13. KNEE DISLOCATION
    a. Splint in position
14. FOOT FRACTURES
    a. Splint
15. JAW (maxillo-facial trauma)
    a. Maintain airway
    b. Suction as necessary
    c. Consider C-spine immediately
    d. Position patient to maintain a patent airway
    e. Collect broken teeth, place in moist, sterile saline gauze and plastic bag
16. TRAUMATIC AMPUTATIONS
    a. Control bleeding
    b. Care of amputated part:
        1. Rinse amputated part gently with sterile irrigation saline to remove loose debris/gross contamination
        2. Place amputated part in dry, sterile gauze and in a plastic bag surrounded by ice; prevent direct contact

NEWBORN CARE

FIELD ASSESSMENT/TREATMENT INDICATIONS

Field delivery with or without complications

BLS INTERVENTIONS

1. When head is delivered, suction mouth then the nose, and check to see that cord is not around baby's neck.
2. Dry infant and provide warm environment. Prevent heat loss (remove wet towel)
3. Place baby in supine position at or near the level of the mother's vagina. After pulsation of cord has ceased double clamp cord at approximately 7" and 10" from baby and cut between clamps.
4. Maintain airway, suction mouth and nose
5. Provide tactile stimulation to facilitate respiratory effort
6. Assess breathing if respirations <20 or gasping, provide tactile stimulation, and assisted ventilation if indicated
7. Circulation
   a. Heart Rate <100 ventilate BVM with 100% O_2 for 30 seconds and reassess. Repeat if HR remains <100
   b. Heart Rate <60 begin chest compressions (rate 120 times/min) and provide BVM ventilation at a rate of 40-60 breaths/min with 100% O_2, reassess.
8. Central cyanosis is present, utilize supplemental O_2 at 10 to 15L/min using oxygen tubing close to infants nose and reassess. If no improvement is noted after 30 seconds assist ventilation with BVM
9. Obtain Apgar scoring at one (1) and five (5) minutes Do not use Apgar to determine need to resuscitate

APGAR SCORE

SIGN	0	1	2
Heart Rate	Absent	< 100/minute	> 100/minute
Respirations	Absent	<20/irregular	>20/crying
Muscle Tone	Limp	Some Flexion	Active Motion
Reflex Irritability	No Response	Grimace	Cough or Sneeze
Color	Blue or pale	Blue Extremities	Completely Pink

ALS INTERVENTIONS

1. Obtain vascular access via IV/IO if indicated
2. Consider advanced airway per Protocol Reference #4011 if BVM is ineffective or tracheal suctioning is required Reassess placement after every intervention
3. Epinephrine 0.01mg/kg IV/IO (1:10,000) or 0.1mg/kg ET (1:1,000) if Heart Rate <60 after one (1) minute
4. Place Orogastric tube if positive pressure ventilation is used >2 minutes
5. Obtain Blood Glucose by heel stick, if <40 give D25 0.5gms/kg IV

6. Contact Base Hospital if hypovolemia is suspected. Base Hospital may order 10-20ml/kg IV NS over 5 minutes. If unable to contact Base Hospital and transport time is extended give 10ml/kg IV NS over 5 minutes, may repeat.
7. For persistent hypotension despite adequate ventilation and fluid resuscitation, Base Hospital may order Epinephrine 0.005mg/kg (1:10,000) IV/IO every 10 minutes. If unable to contact Base Hospital and transport time is extended give indicated dosage and contact Base Hospital as soon as possible

OBSTETRICAL EMERGENCIES

UNCOMPLICATED DELIVERY

BLS INTERVENTIONS

1. Administer Oxygen as clinically indicated
2. Prepare for delivery
3. Massage fundus if placenta delivered

COMPLICATED DELIVERY

BLS INTERVENTIONS

1. Excessive vaginal bleeding prior to delivery
   a. Attempt to contain bleeding. Do not place anything into vagina
   b. Trendelenberg position
2. Prolapsed Cord
   a. Hips elevated
   b. Gently push presenting part of head away from cord
   c. Consider knee/chest position for mother
3. Post Partum Hemorrhage
   a. Massage fundus to control bleeding
   b. Encourage immediate breast feeding
   c. Trendelenburg position
4. Cord around infant's neck
   a. Attempt to slip cord over head
   b. If unable to slip cord over head, deliver the baby through the cord
   c. If unable to deliver the baby through the cord, double clamp cord, then cut cord between clamps
5. Breech presentation and head not delivered within 3-4 minutes
   a. Hi-flow O_2 on patient
   b. Trendelenburg position
   c. Code 3 to closest appropriate facility
6. Pregnancy induced hypertension and eclampsia
   a. Seizure precautions
   b. Attempt to reduce stimuli
   c. Limit fluid intake
   d. Monitor and document B/P
   e. Consider left lateral position

ALS INTERVENTIONS

1. Obtain IV access, and maintain IV rate as appropriate
2. Excessive vaginal bleeding or post-partum hemorrhage
   a. Give fluid challenge of 500ml, If signs of inadequate tissue perfusion persist may repeat fluid bolus
   b. Maintain IV rate at 150ml/hr
   c. Establish 2nd large bore IV enroute
3. Pregnancy Induced Hypertension / Eclampsia
   a. IV TKO, limit fluid intake
   b. Obtain O_2 saturation on room air, if possible
   c. Place in left lateral position, and obtain BP after 5 minutes
   d. Obtain rhythm strip with copy to receiving hospital
   e. For tonic/clonic activity:
      i. Magnesium Sulfate 4gms diluted with 20ml NS, IV/IO over 3-4 minutes
      ii. Midazolam 2.5mg IV/IO may repeat for a maximum dose of 5mg IV/IO, or Midazolam 5mg IM may repeat for a maximum dose of 10mg IM if unable to establish vascular access
4. Consider immediate notification of Base Hospital physician
5. Base Hospital physician may order:
   a. Dopamine infusion at 400mg in 250ml NS titrated between 5 – 20mcg/min to maintain adequate tissue perfusion
   b. Magnesium Sulfate infusion of 2grams Magnesium Sulfate in 100ml of NS at 30ml/hour after initial administration of 4 grams Magnesium Sulfate.
   c. Repeat dose of Midazolam after 10 minutes for continued tonic/clonic activity
6. In radio communication failure (RCF) the following medications may be given:
   a. Dopamine infusion at 400mg in 250ml NS titrated between 5 – 20mcg/min to maintain adequate tissue perfusion
   b. Magnesium Sulfate infusion of 2grams Magnesium Sulfate in 100ml of NS at 30ml/hour after initial administration of 4grams Magnesium Sulfate
   c. Repeat dose of Midazolam after 10 minutes for continued tonic/clonic activity

APPROVED:

ICEMA Medical Director — Date: 2-28-06

San Bernardino Co. Health Officer — Date: MAR 0 8 2006

Inyo Co. Health Officer — Date: 3/16/06

Mono Co. Health Officer — Date: 3/21/06

ICEMA Executive Director — Date: 3/23/06

MEDICAL RESPONSE TO A MULTI-CASUALTY INCIDENT

PURPOSE

To provide a written guideline to assist EMS personnel in determining if a multi-casualty incident exists, and to provide general guidelines in handling the incident consistent with the Incident Command System (ICS).

DEFINITIONS

Multi-Casualty Incident: Any incident where EMS personnel and equipment are not adequate to care for all victims.

S.T.A.R.T.: Acronym for simple triage and rapid transport. The S.T.A.R.T. system allows first responders to triage patients in sixty (60) seconds or less, based on three physical assessments; ventilation, perfusion and mental status. This is the initial triage system that has been adopted for use by the ICEMA regions.

Deceased: No ventilations present even after attempting to position airway.

Immediate: Ventilation is present only after positioning the airway.

Or **Respirations** over 30 per minute
Or **Pulse** absent and Cap refill over 2 seconds
Or **Mental Status** patient fails to follow simple commands.

Delayed: Any patient who does not fit the Immediate Category nor the minor category.

Minor: These patients are separated from the general group at the start of the triage by requesting those who can walk to go to an assigned area

Incident Command System (ICS): Developed by Firescope, a basic expandable organization system for handling emergencies beyond the capabilities of an initial resource response.

Incident Commander (IC): Individual responsible for the overall management of the incident.

Triage: The continuous screening and classification of sick and injured victims.

Triage Tag: A tag used by triage personnel to identify and document the patients' medical condition.

REDDINET: A communications system within San Bernardino County linking COMM Center and medical facilities during an MCI providing for rapid patient assignments to appropriate facilities.

Coordinating Facility: The coordinating facility will alert regional hospitals and coordinate victim transportation so that no single hospital is overloaded. The following communications centers have been identified as the primary resources for coordinating multiple casualty incidents in their respective counties:

1. San Bernardino County – COMM Center
2. Inyo County – To be announced
3. Mono County – To be announced

PROCEDURE

Operational Principles for Prehospital Personnel

1. First arriving resource with the appropriate communications ability shall report to or establish an Incident Command and remain in control until relieved by the jurisdictional authority.
2. The IC will assign the first available resource with appropriate communications ability to establish communications with the Coordinating Facility and the next arriving resources should become triage personnel.
3. Patients are triaged according to S.T.A.R.T. system and ICS is implemented according to Firescope,

4. The ICS system is expanded accordingly;
   a. **Reinforced Response Organization**: In addition to the initial response, the Incident Commander designates a Triage Unit Leader, a Treatment Unit Leader, Treatment Teams, and a Ground Ambulance Coordinator.
   b. **Multi Leader Response Organization**: The Incident Commander will establish an Operations Section Chief who will in turn establish a Medical Supply Coordinator, a manager for each treatment category and a Patient Transportation Group Supervisor.
   c. **Multi Group Response:** All positions within the Medical Group and Patient Transportation Group are filled. An Air Operations Branch may be designated to provide coordination between the Air Ambulance Coordinator and the Air Operations Branch. An Extrication Group may be designated to coordinate the extrication of trapped victims.
   d. **Complete Incident Organization**: The Multi Casualty Branch will have three medical divisions (geographically separate) but only one Patient Transportation Group.

Operational System Description (OSD)

The Multi-Casualty organizational module is designed to provide for the necessary supervision and control of essential functions required during an MCI. The primary functions will be directed by the Medical Group Supervisor, if activated (or Operations), who reports to the Multi-Casualty Branch Director, if activated (or I.C.) Resources having direct involvement with patients are supervised or coordinated by one of the functional leaders or coordinators.

The functional positions under the Medical Group Supervisor (Operations) are:

1. Medical Communication Coordinator - (Med Comm): Maintains communications with the Coordinating Facility (Example: S.B. Co. Comm Center). Responsible for reporting location, mechanism, and approximate number of Immediate, delayed and minor patients, requesting hospital availability and determining patient transportation and destination decisions.
2. Triage Unit Leader - Supervises triage personnel, who perform the actual triage of patients. Once triaged, patients are moved to the Treatment Unit, usually via backboard or litters carried by litter bearers.
3. Treatment Unit Leader - Supervises personnel assigned to treat patients in the three treatment areas. Assumes responsibility for treatment, preparation for transport, coordination of Pt. treatment and directs movement of patients to the loading area.
4. Ambulance Coordinator - Manages the Air/Ground Ambulance staging Areas and dispatches ambulances as requested.
5. Patient Transportation Group Supervisor - Responsible for the transportation and ensuring records relating to patient identification, injuries, transportation and destination with Medical Communications Coordinator. Requests ambulances from Ambulance Coordinator.

Operational Procedure

1. The Incident Commander or designee will act as the Medical Communication Coordinator (Med Comm) and contact the Coordinating Facility in their county and report a size-up (including location, mechanism, and approximate number of immediate, delayed, and minor patients.)
2. The Coordinating Facility will alert all Hospitals and Trauma Centers by neighborhood and inventory their casualty capability using REDDINET or other available means.
3. The Treatment Unit Leader will notify Med Comm when a patient is ready for transportation and of any special needs (e.g.: Burns, Pediatrics etc.).
4. Med Comm will consult with the Treatment Unit Leader to group patients for transport.
5. Med Comm will notify the Transportation Unit Leader when a patient or group of patients is ready for transport.

6. The Transportation Group Supervisor will then call for an ambulance or other designated transportation vehicle to respond to the loading area.
7. Med Comm will notify the Coordinating Facility of patient departure and include:
   a. Transport Unit No.
   b. Number of Patients
   c. Disposition of Patients
   d. Destination and ETA
8. The Coordinating Facility will advise the destination hospitals with this information via Reddinet or other approved method. Injuries particularly necessitating respiratory, Neuro, or vascular specialties and any needs for decontamination.
9. Each transporting unit should make contact with the facility designated to receive their patient. This contact should be brief and concise and advise that facility of the following:
   a. Transporting unit number
   b. Age/Sex
   c. Method of Injury
   d. Chief Complaint and injuries that may need specialty services such as: respiratory, neuro, or vascular and need for decontamination
   e. Glascow Coma Scale (GCS)
   f. BP (as available)
   g. Estimated time to arrive

Transportation

1. The Incident Commander will designate an ambulance staging area. Ambulance personnel should stay with their vehicle to facilitate rapid transport unless reassigned by the Incident Commander or his designee.
2. The Patient(s) will move or be moved from the treatment area to the loading area.
3. The Transportation Group Supervisor will copy the information from the triage tag onto a Patient Transportation Log and confirm destination with the ambulance crew
4. The Transportation Group Supervisor will notify Med Comm of patient departure.

Medical Control

1. At the scene of a Multi-Casualty Incident, EMS personnel will operate within ICEMA prior to contact protocols.
2. A paramedic may contact a designated Base Hospital (within San Bernardino County a Trauma Base shall be contacted) with a concise report and request for orders if needed.

Field Documentation

1. The Medical Communications Coordinator is responsible for:
   a. The primary multi-casualty incident O1A form. This will include:
      i. Name and location of incident
      ii. Patient tracking tag/ number for each patient attached, with indication of destination noted (to be received from Treatment Unit Leader or Treatment Dispatch Manager).
   b. O1A documentation of deceased individuals at the incident.
   c. O1A documentation of patients with a chief complaint who refuse treatment and sign a release of liability or AMA
2. The transporting personnel are responsible for an O1A for each patient he/she transports. This will include patient tracking tag/number and will indicate the incident location

Receiving Hospital and Base Hospital Procedures in San Bernardino County

1. All hospitals will notify the Coordinating Facility of their bed availability via Reddinet
2. The Coordinating Facility will notify receiving facilities of patient destinations.
3. A receiving facility may not change the destination of a patient.
4. A Trauma Base Hospital physician may change a patient destination if a patient condition deteriorates.
5. All facilities receiving patients from a MCI will enter the appropriate information into the Reddinet.
6. Coordinating Facility will notify hospitals via Reddinet when all patients have left scene.

MEDICAL RESPONSE TO HAZARDOUS MATERIALS INCIDENT

PURPOSE

To supplement the Operational Area Plan Hazardous Material Response Policy. To provide a more detailed medical perspective and serve as a guide to dispatch centers, EMS response agencies, (both public and private) and acute care hospitals and to outline a plan of coordinated medical response to victims of hazardous materials incidents for decontamination, protective measures, and treatment.

DEFINITIONS

"Exclusion Zone" or "Hot Zone" is that area immediately around the spill where contamination does or could occur. It is the innermost of the three zones of a hazardous materials site. It is the zone where mitigation measures take place. Special protection is required for all personnel operating in this zone. All personnel exiting this zone will require decontamination.

"Contamination Reduction Zone" or "Warm Zone" is that area between the Exclusion Zone and the Support Zone. This zone contains the Contamination Reduction Corridor where the decontamination team decontaminates the personnel leaving the Exclusion Zone. This zone may require a lesser degree of protective equipment than the Exclusion Zone. This area separates the contaminated area from the clean area and acts as a buffer to reduce contamination of the clean area. No contamination should pass through to the clean area.

"Support Zone" or "Cold Zone" is the clean area outside of the Contamination Control Line. Personnel and equipment are not expected to become contaminated in the area. Special protective clothing is not required. This is the area where resources are assembled to support the hazardous materials operation.

PROCEDURE

Operational Principles for Respoinders

1. There is a direct relationship between the type and amount of material and the resultant illness. Exposure may lead to injury and death. Risk to personnel is directly related to the type of contaminant and length of exposure.
2. A single small release, with any degree of personal carelessness, could disable an entire emergency medical system.
3. On-scene personnel safety takes priority over any immediate rescue/ resuscitation concerns.
4. Pre-hospital health care providers will be unable to respond to other emergencies until decontamination of involved equipment and personnel is accomplished.

Response and Activation

1. Immediate notification to the County Interagency Hazardous Materials Emergency Response Team through appropriate dispatch center.
2. Information (if known) to be provided to responding agencies:
   a. Name of substance (this could include basic information such as container information, placards, color/size/odor descriptions, and should be obtained from a safe distance); do not make an effort to smell any chemical as this could result in an adverse exposure to response personnel.
   b. Physical state of material (liquid, gas, powder, etc.).
   c. Extent of contamination.
   d. Lay of the land.

e. Wind direction, other weather conditions.
f. Staging area, sic. upwind, upstream, uphill.
g. Alternate travel route.
h. Consider activation of MCI if appropriate.

Hospital Notification

In all cases, hospitals should immediately be made aware of any hazardous materials involved through the ReddiNet system or by phone. This early alert will allow the hospital(s) to prepare for the eventuality of receiving patients from the incident. This notification should be made even if it appears no victims have received exposure or contamination. This pre-notification also allows lead-time to establish a screening program thereby minimizing the potential for contamination of the facilities by arriving victims who have not otherwise been screened at the incident site by responders.

First Responding Ambulance

1. If an ambulance is the first responder, upon suspicion of a hazardous material release, the crew should:
   a. Advise the appropriate dispatch center of the situation. This information will minimize unnecessary and inadvertent exposure to other public safety personnel and equipment.
   b. The ambulance crew shall await arrival of appropriate resources prior to rendering any treatment.
2. Medical responders will always work in the Support Zone. They should never enter the Exclusion or Contamination Reduction Zones.
3. The IC will determine the level of personal protective equipment (PPE) needed in all of the zones.
4. Only personnel who are wearing proper personal protective equipment (PPE) shall make contact with victims in the Exclusion or Contamination Reduction Zones
5. The Incident Commander or designee will make all decisions regarding the mode of transportation for injured persons.

On Site Treatment

1. Within the Exclusion and Contamination Reduction Zones
   Self-contamination potential and restrictions caused by PPE make definitive treatment within these zones difficult. Those trained in providing medical care in a hazardous environment, and limited to basic life support procedures should provide medical treatment within these zones. This treatment should be followed by rapid transportation to the Containment Reduction Zone/ Decon. Any ambulatory victims need to be directed to an Ambulatory Decon Area/Line for decontamination. It is possible some of these people can decontaminate themselves.
2. The Safe Zone
   Paramedic medical interventions should begin only after the decontamination process. Treatment should be in accordance with prevailing medical standards of care and by consultation with the base hospital, if indicated. One hospital should act as the coordinating hospital using resources such as Regional Poison Control Center and/or Toxic Information Center.
3. In some cases, individuals may arrive at local hospitals without going through decontamination. Hospitals should be prepared for this possibility. Hospital security or other staff persons should be notified and located by the hospital main and emergency entrance doors. Personnel should question every entrant as to their reasons for coming to the hospital. Preliminary screening should ensure that persons who are contaminated at the incident and who have not been through field decontamination are isolated and restricted from entering the hospital. These victims have the potential for exposure risk and contamination of personnel and facilities. Contamination could result in the lengthy shutdown of a facility while specialized decontamination teams render the facility safe.

Medical Transportation

1. Ground Ambulance Preparation
   a. If a victim is contaminated, there will be no transport until gross decontamination is performed. A contaminated patient should not be transported to a hospital via ambulance. If it is necessary then:
      i. A plastic sheet should be placed on the ambulance floor prior to transport.
      ii. Adequate ventilation should be provided to avoid accumulation of toxic chemical levels in the ambulance.
2. Helicopter Consideration
   a. A decision to utilize helicopter services should be decided by the collaboration of the Incident Commander, or designee and the flight crew.
   b. Guidelines outlined in the previous section (ground transportation) should be applied to preparing a helicopter prior to transporting patients.

Determination of Destination Hospital and Related Preparation

1. Destination Hospital
   The destination hospital should be determined by the standard of the closest, and most appropriate. When information indicates the hazardous material possesses a significant threat to hospital personnel, consideration should be given in consultation with the Base Hospital Physician to triage the patients to a single hospital. This decision should be made based on the potential danger to attending staff, threatened facility closure and the ability of the hospital to handle such cases.
2. Preparation by Receiving Hospital(s)
   a. Internal preparation according to hospital policies and procedures.
   b. Anticipate walk-in contaminated patients.
   c. Anticipate the need for fine detail decontamination (e.g. fingernail beds and ear canals of persons who were field decontaminated). Check for contact lenses.
   d. In the event contaminated victims arrive at the hospital by private means (i.e. not decontaminated in the field), the hospital should be prepared to decontaminate victims outside the Emergency Department. This should be a pre-designated area dedicated for this purpose. Some accessories may include:
      i. Temperature controlled water hose (low pressure).
      ii. Kiddie pool or other acceptable catch basin.
      iii. Expendable or easily decontaminated gurney.
      iv. Towels and sheets for patient.
      v. Movable screens for privacy.
      vi. Plastic lined garbage receptacles for contaminated clothes and equipment.
      vii. A current contract with a State licensed hazardous materials contractor to dispose of contaminated materials and properly perform area decontamination should already be in place.

Base Hospital Medical Control Roles and Responsibilities

1. Assignment of a Mobile Intensive Care Nurse/Emergency Department Physician or designee to ReddiNet, if available, throughout the duration of the incident.
2. Collaboration of Base Hospital Physician and the Incident Commander/Technical Reference Team Leader as to the best method of decontamination.
3. Provide to paramedics, on-line information regarding prodromal symptoms that may be expected as a result of exposure to hazardous materials.
4. Anticipate walk-in contaminated patients and initiate appropriate action.
5. Assist in consultation and determination of destination

Decontamination of Prehospital Equipment and Personnel

Proper protection of equipment and supplies should minimize equipment and personnel out of service due to any contamination that may occur during transport. If the vehicle and equipment are contaminated during transport, they should not return to service until adequately decontaminated by qualified personnel. In addition, the following procedure should be followed:

1. Personal protective garments should be discarded in designated receptacles at hospital facilities as soon as practical.
2. Decontamination should take place under the direction of designated hazardous materials personnel.
3. Decontamination should take place in an area where wastewater can be contained.
4. No medical vehicle, associated hardware, or supplies shall be released for service until clearance is received from designated hazardous materials personnel.

INTER-FACILITY TRANSPORT

PURPOSE
To identify patient care responsibilities for EMT-I and EMT-Ps during inter-facility transports

AUTHORITY
Title 22, Division 2.5, Sections 1797.214, 1798.170, and 1798.172 of the California Health and Safety Code

BLS POLICY
During an inter-facility an EMT-I or supervised EMT-I student may monitor the following during an inter-facility transport if the patient is non-critical and deemed stable by the transferring physician and the physician has approved transport via BLS ambulance:

1. Monitor a saline lock or peripheral lines delivering fluids in any combination/concentration of Normal Saline, Lactated Ringers, Isolyte or Isolyte M or Dextrose and Water provided the following conditions are met.
   a. No medications have been added to the IV fluid.
   b. Maintain the IV at a pre-set rate.
   c. Check tubing for kinks and reposition arm if necessary.
   d. Turn off IV fluid if signs/symptoms of infiltration occur.
   e. Control any bleeding at insertion site.
2. Transport a patient with a Foley catheter provided:
   a. The catheter is able to drain freely.
   b. No action is taken to impede flow or contents of drainage collection bag.
3. Transport a patient with a nasogastric or gastrostomy tube provided:
   a. The tube is clamped
   b. All patients who have received fluids prior to transport are transferred in a semifowler position to prevent aspiration, unless contraindicated.
4. If the patient's condition deteriorates, the patient should be transported to the closest receiving hospital.

ALS POLICY
During an inter-facility transport, an ICEMA Accredited EMT-P or supervised EMT-P intern may:

1. Monitor peripheral lines delivering fluids in any combination/concentration of normal saline, lactated ringers, isolyte or isolyte M or dextrose and water provided the following conditions are met:
   a. A written order by the transferring physician is provided to the transporting ALS ambulance.
   b. No medications will be added to the intravenous fluids by the EMT-P during transport except under direction of the Base Hospital or under radio communication failure.
2. Transport intravenous solutions with added medication (s) as follows:
   a. Lidocaine
   b. Dopamine
   c. Procainamide
   d. Magnesium Sulfate
   e. Pitocin (if trained)
3. Monitor and administer medications through a pre-existing vascular access
4. Monitor heparin lock or saline lock

5. Monitor IV solutions containing potassium ≤40mEq/L
6. Monitor thoracostomy tubes to water sealed drainage, or clamped thoracostomy tubes
7. Monitor nasogastric tubes
8. Contact assigned Base Hospital per Protocol Reference #14009 Radio Communication if patient condition deteriorates in route.

APPROVED:

ICEMA Medical Director Date

San Bernardino Co. Health Officer MAR 0 8 2006 Date

Inyo Co. Health Officer 3/16/06 Date

Mono Co. Health Officer 3/2/06 Date

ICEMA Executive Director 3/23/06 Date

INTERFACILITY TRANSPORT NURSE STAFFED UNITS

PURPOSE

To state the requirements for nurse-staffed ALS Interfacility transport units meeting all local, county, ICEMA and state requirements.

AUTHORITY

Title 22, Division 2.5, Sections 1797.52, 1797.178, 1798.170, and 1798.172 of the California Health and Safety Code.

PROGRAM APPROVAL

1. Requests for approval must be made in writing sixty (60) days prior to the anticipated starting date of service to the Executive Director of ICEMA and include:
   a. Proposed identification and location of the nurse-staffed unit
   b. All procedures and protocols
   c. Documentation of qualifications for the Medical Director
   d. Documentation of qualifications for the Nursing Coordinator
   e. Quality assurance plan
   f. Agreement to comply with all ICEMA policies and procedures
2. ICEMA will notify the applicant in writing within ten (10) working days following receipt of request for approval if any further documentation is needed
3. The applicant shall be notified in writing within thirty (30) days of receipt of complete package of the approval or denial of the program

REQUIREMENTS FOR REGISTERED NURSE PERSONNEL

1. RN currently licensed to practice in the State of California
2. At the provider's option, an RN may be employed by the ambulance provider or be a contract employee
3. Current BLS, ACLS and PALS certification from the American Heart Association or equivalent
4. A minimum of two (2) years experience in an ICU or ED in the previous three (3) years, prior to employment with the ambulance provider
5. Successful completion of an in-house orientation program related to ICEMA protocols and procedures and Endotracheal Intubation training
6. Certification in any of the following is desirable but not required: Certified Emergency Nurse (CEN); Critical Care Registered Nurse (CCRN); Mobile Intensive Care Nurse (MICN)
7. Continuing education requirement documentation:
   a. Minimum of ninety-six (96) hours of ICU or ED experience per year
   b. Minimum of two (2) successful Endotracheal Intubations every two (2) years
   c. Maintain current California State RN license, BLS, ACLS and PALS certification

EQUIPMENT

In addition to the items required by California Administrative Code, Title XIII, the ambulance provider shall provide, at a minimum, the following equipment:

1. ALS Equipment per Protocol Reference #2001 ALS Standard Drug & Equipment List
2. Cardiac monitor **with external pacemaker**
3. Infusion pump(s)
4. Back-up power source

MEDICAL DIRECTOR

1. Medical Director: A full or part-time Physician licensed in the State of California and qualified by training and experience with recent, within the last five (5) years, practice in emergency or acute critical care medicine. The ICEMA Medical Director must approve the candidate for medical director. The duties of the medical director shall include but not be limited to:
   a. Sign and approve, in advance, all medical protocols to be followed by the RN at the ALS level
   b. Ensure the ongoing training of all medical personnel involved
   c. Ensure the quality of patient transfers being conducted by the provider, including familiarity with SB612 and COBRA laws
   d. Ensure that quality assurance outcome audits are being conducted
2. Nursing Coordinator: A full or part-time RN employed as Nursing Coordinator qualified by training and/or experience with recent practice in emergency or acute critical care nursing. The duties of the Nursing Coordinator shall include but not be limited to:
   a. Sign and approve, in advance, all nursing procedures to be followed by the RN at the ALS level
   b. Provide ongoing training of all medical personnel involved
   c. Ensure quality of patient transfers being conducted by the provider by conducting patient care audits

PROCEDURES/PROTOCOLS

1. Each company providing nurse-staffed ALS units shall develop and maintain procedures for the hiring and training of nursing personnel and vehicle staffing
2. Each provider must develop a manual to include the following:
   a. Malpractice insurance coverage
   b. Identity and accessibility of the Physician Director and Nursing Coordinator
   c. Vehicle inventory lists
   d. Copies of all related inter-facility transfer paperwork
   e. Statement of responsibility of the sending physician for the patient during transfer and in accordance with COBRA and SB612 laws
   f. Guidelines for change in patient destination due to patient condition
   g. Protocols (Standing Orders) based on ACLS, PALS, and/or NALS guidelines
3. Procedures and protocols shall be subject to review by ICEMA

QUALITY ASSURANCE

1. Submit to ICEMA a quality improvement plan and submit quarterly reports to ICEMA
2. All transports resulting in poor patient outcome shall be reviewed in a timely manner following the occurrence
3. Periodic staff conferences on audit and outcomes are required in order to improve or revise protocols.
4. Records of all these activities shall be kept by the provider and be made available for inspection and audit by ICEMA
5. ICEMA shall perform periodic on-site audits of records to ensure compliance with this policy

6. Compliance with this policy may cause ICEMA to suspend or revoke approval of a nurse-staffed ALS inter-facility transport unit

APPROVED:

ICEMA Medical Director Date

MAR 0 8 2006

San Bernardino Co. Health Officer Date

James Richardson MD 3/16/06

Inyo Co. Health Officer Date

3/24/06

Mono Co. Health Officer Date

ICEMA Executive Director Date

TRANSPORT OF PATIENTS

In the prehospital setting or during inter-facility transport, a certified EMT-I or supervised EMT-I trainee who has received appropriate training may monitor peripheral lines delivering intravenous fluids, Foley catheters, heparin locks, nasogastric tubes, and gastrostomy tubes under Section 10015(b), Title 22 of the California Health and Safety Code provided the following conditions are met:

1. An EMT-I may monitor peripheral lines delivering intravenous fluids during inter-facility transport and in the prehospital setting with the following restrictions:
   a. The patient is non-critical and deemed stable by the transferring or base hospital physician and the physician approves transport by an EMT-I, and
   b. No medications have been added to the intravenous fluids, and
   c. In the prehospital setting, no other advanced life support procedures have been initiated.
2. The EMT-I shall:
   a. Monitor and maintain the IV at a preset rate, and
   b. Check the tubing for kinks and reposition the arm if necessary when loss of flow occurs,
   b. Control the bleeding at the IV site; and
   d. Turn off the flow of intravenous fluid if infiltration or alteration of flow occurs. Vital signs should then be monitored frequently.
   e. Transfer patient with any combination/concentration of:
      i. D5/water with or without:
         1.) Normal Saline
         2.) Lactated Ringers
         3.) Isolyte or Isolyte M
      ii. Normal Saline
      iii. Lactated Ringers
3. An EMT-I may transport a patient with a heparin lock provided:
   a. The patient is noncritical and deemed stable by the transferring Physician or Base Hospital physician and the physician approves transport by an EMT-I.
   b. The EMT-I shall:
      i. Monitor the heparin lock only as placed at time of transfer, and
      ii. Control any bleeding at insertion site.
4. An EMT-I may transport a patient with a Foley catheter provided:
   a. The patient is noncritical and deemed stable by the transferring Physician or Base hospital Physician and the physician approves transport by an EMT-I, and
   b. The catheter is able to drain freely to gravity, and
   c. No action is taken to impede flow or disrupt contents of drainage collection bag.
5. An EMT-I may transport a patient with a nasogastric tube or gastrostomy tube provided:
   a. The patient is noncritical and deemed stable by the transferring Physician or Base Hospital Physician and the physician approves transport by an EMT-I, and
   b. Nasogastric and gastrostomy tubes are clamped, and
   c. All patients who have received fluids prior to transport are transferred semi fowlers to prevent aspiration, unless contraindicated.
6. If at any time the patient's condition deteriorates, the patient should be transported to the closest Receiving Hospital.

PHYSICIAN ON SCENE

PURPOSE
To establish criteria for an EMT-Paramedic during situations in which a physician is physically present on the scene of a medical or trauma emergency.

AUTHORITY
Division 9, Chapter 4, Article 2, section 100147 and Article 8, section 100175 of the California Code of Regulations

POLICY
Medical responsibility for patient care is the responsibility of the Base Hospital Physician. Within the ICEMA Region an EMT-P may only follow orders given by the Base Hospital Physician or designee (MICN)

PROCEDURE

There may be occasions when an EMT-P arrives at the scene of a medical or a trauma emergency, and a physician is also on scene or may arrive on scene. If this physician wishes to direct the care of the patient as well as assume medical responsibility for the patient, the physician must agree to the following conditions

1. The physician must be informed that Base Hospital contact must be made and the final decision regarding the assumption of medical responsibility for patient care will be made by the Base Hospital physician.
2. The physician must show proper identification and a current California physician's license.
3. The physician must agree to sign a written statement assuming responsibility for the patient's care. This statement is on the back of the first copy of the Standard Run Report Form and may be signed either on scene or in the receiving facility's Emergency Department.
4. The physician must remain with the patient at the scene and during transport to the receiving facility. Care of the patient may be transferred to a physician at the receiving facility after the ambulance arrives.

If the above conditions are agreed to, a physician on scene may assume the responsibility for patient care.

EMT-P RESPONSIBILITIES

The EMT-P has the following responsibilities in the event that a physician is on the scene of a medical or trauma emergency.

1. Maintain Base Hospital contact
2. Maintain the control of drugs and equipment from the ALS unit. Inform the physician of drug and equipment available on the ALS unit
3. Offer assistance to the physician on scene. The EMT-P may perform any procedures that are within the ICEMA scope of practice
4. Document on O1A Form all necessary information and obtain physician signature

SUSPECTED SUDDEN INFANT DEATH SYNDROME INCIDENT

It is imperative that all pre-hospital personnel in ICEMA are able to assist the caregiver and local police agencies during a suspected SIDS Incident.

PROCEDURE

1. Follow individual department/agency policies at all times.
2. Ask open-ended questions about incident.
3. Explain what you are doing, the procedures you will follow, and the reasons for them
4. If you suspect a SIDS death, explain to the parent/caregiver what SIDS is and, if this is a SIDS related death nothing they did or did not do caused the death.
5. Provide the parent/caregiver with the number of the California SIDS Information Line:

   1-800-369-SIDS (7437).
6. Provide psychosocial support and explain about the emergency treatment and transport of their child.
7. Assure the parent/caregiver that your activities are standard procedures for the investigation of all death incidents and that there is no suspicion of wrongdoing.

RESPONSIBILITY FOR PATIENT MANAGEMENT

PURPOSE

To define the responsibility for patient health care management in an emergency. Within the ICEMA region, in the event both public and private emergency medical care personnel arrive on the scene with the same qualifications, patient management responsibility will rest with the first to arrive.

AUTHORITY

Health & Safety Code, Division 2.5, Chapter 5, Section 1798.6 (a & c)

a) Authority for patient health care management in an emergency shall be vested in that licensed or certified health care professional, which may include any paramedic or other pre-hospital emergency personnel, at the scene of the emergency who is most medically qualified specific to the provision of rendering emergency medical care.

If no licensed or certified health care professional is available, the authority shall be vested in the most appropriate medically qualified representative of public safety agencies who may have responded to the scene of the emergency.

(c) Authority for the management of the scene of an emergency shall be vested in the appropriate public safety agency having primary investigative authority. Public safety officials shall consult emergency medical services personnel or other authoritative health care professionals at the scene in determination of relevant risks.

PROCEDURE

1. An EMT-P may transfer patient management responsibility to an EMT-I for transportation, **without Base Hospital direction**, only under the following conditions:
   a. When the patient does not meet criteria for Base Hospital contact and has not received ALS care
   b. When operating under the MCI Protocol, Reference #12001
   c. When operating under the Local Medical Emergency Protocol, Reference #14029
2. The Base Hospital should be contacted if at any time transfer of patient management responsibility is in question or for any patient not meeting the above criteria.
3. In the event of radio communication failure, an ALS unit may not transfer patient management responsibility to an EMT-I for transportation.

REPORTING INCIDENTS OF SUSPECTED CHILD, DEPENDANT ADULT, OR ELDER ABUSE/NEGLECT

Prehospital personnel are required to report incidents of suspected neglect or abusive behavior towards children, dependant adults or elders. These reporting duties are individual, and no supervisor or administrator may impede or inhibit such reporting duties and no person making such report shall be subject to any sanction for making such report.

When two or more persons who are required to report are present at scene, and jointly have knowledge of a suspected abuse, and when there is agreement among them, the telephone report may be made by a member of the team selected by mutual agreement and a single written report may be made and signed by the selected member of the reporting team. Any member who has knowledge that the member designated to report has failed to do so, shall thereafter make the report.

Information given to hospital personnel does not fulfill the required reporting mandated from the state. The prehospital caregivers must make their own report.

CHILD ABUSE/NEGLECT

Suspicion of Child abuse/neglect is to be reported by prehospital personnel by telephone to the Child Abuse Hotline immediately or as soon as possible. Be prepared to give the following information:

a. name of person making report;
b. name of child;
c. present location of child;
d. nature and extent of the abuse/neglect;
e. location where incident occurred, if known; and
f. other information as requested.

San Bernardino County	1-800-827-8724 24-hour number	**or**	1-909-384-9233
Inyo County	1-760-872-1727 M-F 8 am - 5 pm	**or**	911 after hours
Mono County	1-760-932-7291 M-F 8 am - 5 pm	**or**	1-760-932-7755 after hours

The phone report must be followed within 36 hours by a written report on the "***Suspected Child Abuse Report*** " form. Mail this to:

San Bernardino County
CPS
412 W. Hospitality Lane
San Bernardino, CA 92408

Inyo County
CPS
162 Grove St. Suite "J"
Bishop, Ca. 93514

Mono County
Department of Social Services
PO Box 576
Bridgeport, Ca. 93517

The identity of any person who files a report shall be confidential and disclosed only between child protective agencies, or to counsel representing a child protection agency, or to the district attorney in a criminal prose

DEPENDENT ADULT AND ELDER ABUSE

Suspicion of Dependent Adult and Elder Abuse/Neglect should be reported as soon as possible by telephone. Be prepared to give the following information;

a. name of person making report;
b. name, address, and age of the dependent adult or elder;
c. nature and extent of person's condition; and,
d. other information, including information that led the reporter to suspect either abuse or neglect.

San Bernardino County	1-877-565-2020 24-hour number
Inyo County	1-760-872-1727 M-F 8 am - 5 pm **or** 911 after hours
Mono County	1-760-932-7291 M-F 8 am - 5 pm **or** 1-760-932-7755 after hours

The phone report must be followed by a written report within 48 hours of the telephone report on the " ***Report of Suspected Dependent Adult/Elder Abuse***" form. Mail this report to:

San Bernardino County	Department of Aging/Adult Services 881 West Redlands Blvd. *Attn*: Central Intake Redlands, CA 92373 Fax number 1-909-388-6718
Inyo County	Social Services 162 Grove St. Suite "J" Bishop, Ca. 93514
Mono County	Department of Social Services PO Box 576 Bridgeport, Ca. 93517

The identity of all persons who report shall be confidential and disclosed only by court order or between elder protective agencies.

PATIENT REFUSAL OF CARE OR OTHER PATIENT REQUEST

Prehospital personnel should be sensitive to the needs and concerns of the patient and the patient's family. In the event that a competent, conscious patient or legal guardian refuses care offered, or requests to be transported to a hospital other than the nearest, medically appropriate facility, the patient's request should be met.

In the event that a patient refuses treatment, transport, or transport to a medically appropriate destination, the signature of the patient or legal guardian must be obtained on the patient care record. Base Hospital Contact should be made if in the EMT-P's judgment the patient's condition warrants the treatment and/or transport being refused. All patient contacts must be documented on the appropriate patient care record. Patient care records shall be reviewed by the provider agency in accordance with the San Bernardino Co. EMS Quality Improvement Plan and subsequently forwarded to San Bernardino Co. EMS.

Providers may refuse a request to transport a patient to a more distant facility if it lies outside of their service area provided they offer transportation to an appropriate medical facility. In the event the patient or legal guardian insists upon transport and the transporting ambulance agrees to transport to a more distant facility, the signature of the patient or legal guardian must be obtained on the patient care record and Base Hospital Contact made.

GUIDELINES FOR ADULT REFUSAL OF CARE

PURPOSE
To provide guidance for EMS Personnel whose advice to an individual for treatment and/or transport is being refused

AUTHORITY
Health and Safety Code, Section 1797.220

PRINCIPLE
Recognizing that the decision to be transported by a provider agency is solely the responsibility of the individual, a process should be in place to document such "refusal of services", to protect both the individual and EMS personnel. An AMA should be initiated whenever the highest medical authority on scene determines that a person would benefit from assessment, treatment and/or transport and that person refuses

DEFINITION

AMA: A term used to designate "against medical advice"

Consent: Consent is defined as the agreement and acceptance as to opinion or course of action

Emergency: The American Ambulance Association (AAA) defines an "emergency" as "unforeseen condition of a pathophysiological nature, which a prudent layperson, possessing an average knowledge of health and medicine, would judge to require urgent and unscheduled medical attention"

CONSENT

1. Legal consent procedures should not delay immediately required treatment
2. An individual has the responsibility to consent to or refuse treatment. If he/she is unable to do so consent is then considered implied
3. In non-emergency cases, consent should be obtained from the individual
4. For treatment of minors or a definition of emancipated minors refer to Protocol Reference #14023 Care of Minors

MENTAL COMPETENCE

1. An individual is mentally competent if he or she:
   a. Is capable of understanding the nature and consequences of the proposed treatment
   b. Has sufficient emotional control, judgment and discretion to manage his or her own affairs
2. An individual having an understanding of what may happen if treated or not treated, and is oriented to person, place, time and purpose
3. An individual with an altered level of consciousness will be unlikely to fulfill these criteria.
4. If the individual is not deemed mentally competent, the person should be treated and transported. It is preferable under such circumstances to obtain concurrence of a police officer in this course of action.

DOCUMENTATION OF REFUSAL OF CARE

In accordance with these guidelines, the following should be carefully documented on the patient care report Form:

1. The individual's chief complaint, mechanism of injury, level of orientation/level of consciousness
2. Base Hospital Contact per Protocol Reference #14009 Radio Communication
3. Any medical treatment or evaluation needed and refused
4. The need for emergency transportation; also if transport by means other than an ambulance could be hazardous due to the individual's injury or illness.
5. Individual advised that potential harm could result without emergency medical treatment and/or transport
6. Individual provided with a refusal advice sheet, and if he or she would accept the refusal advice sheet
7. A copy of the patient care report Form with the individual's signature of refusal will be kept by the EMS provider agency per Protocol Reference #14012 Requirements for Patient Care Records.

APPROVED:

MAR 0 8 2006
San Bernardino Co. Health Officer Date

3/21/06
Mono Co. Health Officer Date

2-28-06
ICEMA Medical Director Date

James Richardson MD 3/16/06
Inyo Co. Health Officer Date

Virginia Hunting 3/23/06
ICEMA Executive Director Date

DETERMINATION OF DEATH ON SCENE

PURPOSE

To identify situations when an EMT-I or EMT-P may be called upon to determine death on scene.

POLICY

An EMT-I or EMT-P may determine death on scene if pulselessness and apnea are present with any of the following criteria. The EMT-P is authorized to discontinue BLS CPR initiated at scene if a patient falls into the category of obvious death. If any ALS procedures are initiated, only the Base Hospital physician/designee may determine death in the field. In any situation where there may be doubt as to the clinical findings of the patient, BLS/CPR must be initiated and the Base Hospital contacted, per Protocol Reference #14008, Do Not Resuscitate Policy. When death is determined, the County Coroner must be notified along with the appropriate law enforcement agency.

Determination of Death Criteria

1. Decomposition.
2. Obvious signs of rigor mortis such as rigidity or stiffening of muscular tissues and joints in the body which occurs anytime after death and usually appears in the head, face and neck muscles first.
3. Obvious signs of venous pooling in dependent body parts, lividity such as mottled bluish-tinged discoloration of the skin, often accompanied by cold extremities.
3. Decapitation.
4. Incineration of the torso and/or head.
5. Massive crush injury and/or penetrating injury with evisceration or total destruction of the heart, lung and/or brain
6. Gross dismemberment of the trunk.
7. Blunt Trauma.

PROCEDURE

1. If the patient does not meet the above criteria for obvious death, appropriate interventions must be initiated.
2. All patients in ventricular fibrillation should be resuscitated and transported unless otherwise determined by the Base Hospital Physician/designee.
3. If resuscitation efforts are terminated enroute, the patient will be transported to the closest facility.
4. Most victims of electrocution, lightning, and drowning should have resuscitative efforts begun and transported to the appropriate Hospital/Trauma Center
5. Hypothermic patients should be treated per Protocol Reference #10006 Hypothermia – Severe.
6. All terminated resuscitation efforts must have an ECG attached to the patient care report per current AHA ECC guidelines.
7. All conversations with the Base Hospital must be fully documented with the name of the Base Hospital Physician who determined death, times, and instructions on the patient care report.
8. A DNR report form must be completed, if applicable per Protocol Reference #14008
9. A copy of the patient care report must be made available for the coroner.

WITHHOLDING RESUSCITATIVE MEASURES

PURPOSE
To establish criteria for withholding resuscitative measures from person(s) who do not otherwise meet the "Determination of Death" criteria in the pre-hospital setting and/or during inter-facility transport

AUTHORITY
Division 2.5, Sections 1797.220 and 1798 of the California Health and Safety Code

POLICY
The DNR only applies to cardiopulmonary resuscitative measures. An order not to resuscitate is not an order to withhold other necessary medical treatment or nutrition. The treatment given to a patient with a DNR agreement should in all respects be the same as that provided to a patient without such an agreement.

DEFINITIONS
Do Not Resuscitate (DNR): A written order by a physician or the presence of a DNR medallion/bracelet or necklace indicating that an agreement has been reached between the physician and patient/or surrogate that in the event of cardiac or respiratory arrest the following medical interventions will **NOT** be initiated:

Chest compressions,
Defibrillation,
Endotracheal intubation,
Assisted ventilation or
Cardiotonic drugs, e.g., epinephrine, atropine,
Or other medications intended to treat a non-perfusing rhythm

Absent vital signs: Absence of respiration and absence of carotid pulse

DNR medallion/bracelet/necklace: A medallion/bracelet/necklace worn by a patient, which has been approved for distribution by the California Emergency Medical Services Authority (EMSA).

Pre-hospital DNR form: Form developed by the California Medical Association (CMA) for use statewide for pre-hospital DNR requests. This form has been approved by EMSA, and ICEMA. This form should be available to pre-hospital personnel in the form of the white original DNR form or as a photocopy. The original or copy of the DNR form will be taken with the patient during transport. **The DNR form shall not be accepted if amended or altered in any way.**

Pre-hospital Personnel: Any EMS field responder currently certified and/or accredited in San Bernardino, Inyo or Mono Counties

VALIDATION CRITERIA
1. **Statewide Pre-hospital DNR Form** (Appendix A) should include the following to be considered valid.
   a. Patient's name
   b. Signature of the patient or a legal representative if the patient is unable to make or communicate informed health care decisions
   c. Signature of patients' physician, affirming that the patient/legal representative has given informed consent to the DNR instruction
   d. All signatures are to be dated.
   e. Correct identification of the patient is crucial. If the patient is unable to be identified after a good faith attempt to identify the patient, a reliable witness may be used to identify the patient.

2. **DNR medallion/bracelet/necklace**: The DNR medallion/bracelet/necklace is made of metal with a permanently imprinted medical insignia. For the medallion or bracelet/necklace to be valid the following applies:
   a. Patient must be physically wearing the DNR medallion/bracelet/necklace
   b. Medallion/bracelet/necklace must be engraved with the words "Do Not Resuscitate EMS", along with a toll free emergency information telephone number and a patient identification number
3. **Physician DNR orders**: In licensed health care facilities a DNR order written by a physician shall be honored. The staff must have the patient's chart with the DNR order immediately available for EMS personnel upon their arrival.

PROCEDURE

1. EMS personnel shall validate the DNR request.
2. BLS personnel shall continue resuscitative measures if a DNR cannot be validated.
3. ALS personnel shall contact a Base Hospital for direction if a DNR cannot be validated. While ALS personnel are contacting the Base Hospital for direction, BLS treatment must be initiated. If contact cannot be made, resuscitative efforts shall continue.
4. If a patient states he/she wishes resuscitative measures, the request shall be honored.
5. If a family member requests resuscitative measures despite a valid DNR, continue resuscitative measures until Base Hospital contact is made.
6. If a patient expires at home law enforcement must be notified.
7. If a patient expires in a licensed health care facility, the facility has the responsibility to make the appropriate notification.
8. All circumstances surrounding the incident shall be documented on the patient care record. If pre-hospital personnel are unable to copy the DNR form the following shall be documented on the patient care record:
   a. Presence of DNR form
   b. Date of order
   c. Name of physician who signed form
9. A DNR report form with a copy of the patient care report attached must be forwarded to ICEMA within one week by either the PLN at the receiving facility if it is a Base Hospital or by the EMT-P's Agency EMS/QI Coordinator.

SUPPORTIVE MEASURES

1. Medical interventions that may provide for the comfort, safety and dignity of the patient should be utilized.
2. The patient should receive palliative treatment for pain, dyspnea, major hemorrhage, or other medical conditions.
3. Allow any family members/significant others to express their concerns and begin their grieving process.

APPROVED:

ICEMA Medical Director — Date: 2-28-06

San Bernardino Co. Health Officer — Date: MAR 0 8 2006

Inyo Co. Health Officer — Date: 3/16/06

Mono Co. Health Officer — Date: 3/21/06

ICEMA Executive Director — Date: 3/23/06

RADIO COMMUNICATION

PURPOSE

To define the requirements for medical communications between all prehospital personnel, base and receiving hospitals. All patient information, treatment, and the time initiated will be recorded accurately and completely on the patient care O1A Form. No patient names will be given over the radio except at the request of the base hospital physician and with patient approval. ALS transport/non-transport agencies may only accept orders from Base Hospitals within the ICEMA Region.

BLS PROCEDURE

1. Each BLS transport will be equipped with a county approved communication device.
2. For any acute or unstable patient a receiving hospital must be contacted as soon as possible with the following information:
   a. The unit number, EMT-I name, and the situation
   b. The patient description to include age, sex, and approximate weight in kilograms (kg)
   c. Patient's chief complaint and related signs and symptoms, and the mechanism of injury, if appropriate
   d. Vital signs to include blood pressure, pulse, respiratory rate and effort, pupil response, skin vital signs, capillary refill and glascow coma scale.
3. For stable patients or for routine transfers a receiving hospital must be contacted as soon as possible with the following information
   a. The unit number, EMT-I name, and the situation
   b. The patient description to include age, sex, chief complaint/injury BP, pulse, respirations and ETA.

ALS PROTOCOL

1. Each ALS unit (transport and non-transport) will be equipped with a minimum of one (1) mandatory communication device and one (1) optional communication device:
   a. Mandatory Communication Devices
      i. 800 MHZ radio in San Bernardino County
      ii. VHF (MED NET) radio approved for Inyo & Mono Counties only
   b. Optional Communication Devices
      i. UHF (COR) radio approved for Mono County only
      ii. Cellular phone approved for all counties
      iii. Other device as approved
2. Base Hospital contact must be initiated on the following:
   a. All patients with suspected AMI or angina remaining symptomatic following ALS interventions. Unless transport time is insufficient to allow for communication and continued patient care.
   b. Any patient receiving ALS interventions and remaining symptomatic following ALS interventions.
   c. Any patient receiving ALS interventions who refuses transport.
   d. Any patient contact with children under the age of four years prior to leaving scene
   e. Any patient receiving ALS Interventions prior to determining death on scene (Protocol Reference #14007)
   f. Base Hospital contact may also be made on any patient who in the EMT-P's judgment would benefit from Base Hospital consultation.

3. In areas with short transport times or when functioning in radio communication failure (RCF), contact must be made as early as possible with the receiving facility on all transported patients not meeting the criteria for Base Hospital contact.
4. In a declared MCI, base hospital contact will be established per Protocol Reference #12001 Medical Response to a Multi Casualty Incident.
5. When Base Hospital contact is initiated; the following information will be given by the EMT-P unless the Base Hospital waives this information:
   a. The unit number, EMT-P name, and the situation
   b. The patient description to include age, sex, and approximate weight in kilograms (kg)
   c. Patient's chief complaint and related signs and symptoms, and the mechanism of injury, if appropriate
   d. Vital signs to include blood pressure, pulse, respiratory rate and effort, and oxygen saturation if appropriate.
   e. Physical assessment and general appearance
   f. Past medical history, including medications and allergies
   g. Cardiac Monitor interpretation, if appropriate
   h. Prior to contact therapy initiated and response including all medication dosages and route given.
6. After contact, the MICN will provide the following:
   a. Both the MICN and physician names, with time of contact.
   b. Acknowledge any interventions or medications given prior to contact
   c. All medication orders given will state the medication name, dosage and route.
7. Patient destination is the responsibility if the Base Hospital Physician based upon patient condition and patient and/or family/law enforcement request.
   a. Patient request for a certain facility should be honored unless
      i. Patient medical condition is acute and meets criteria for diversion to a closer facility
      ii. Request is for a facility further than 30 minutes away and outside of the transporting agency's EOA. In these cases, the patient will be offered transport to the closest appropriate facility.
      iii. Requested facility is closed due to Internal Disaster.

   b. In cases when a patient request may be determined by the Base Hospital physician to be detrimental to the patient's condition, the patient and/or family/law enforcement must be informed as to the risks up to and including death. All circumstances should be documented on the O1A Form.
8. During an Interfacility Transfer, patient destination may not be changed unless patient condition significantly deteriorates and requires ALS interventions during transport. If a Base Hospital is contacted and patient destination is changed, it is the responsibility of the Base Hospital to notify both the sending facility and the designated receiving facility of this change. An evaluation of these destination changes will be included in the Base Hospital monthly CQI report to ICEMA.
9. Air Transport destination decisions of trauma patients will be determined by a Trauma Base Hospital in San Bernardino County.
   a. The ground crew shall inform the designated air crewmember if a Trauma Base was contacted and if a destination has been determined. The aircrew will continue the call with that Trauma Base Hospital.
   b. The pre-hospital EMS aircrew has a responsibility to identify their personnel designated to receive information from ground personnel.
   c. If the designated trauma receiving facility destination is changed for any reason, the Trauma Base Hospital initially contacted shall be immediately notified of destination change by the aircrew.
   d. ICEMA shall be notified within two hours of any destination change and a QI report forwarded to ICEMA within five days of the transport.

ANNUAL REVIEW CLASS

PURPOSE

To define the eligibility and procedural requirements for the mandatory yearly Annual Review Class (ARC) for the Paramedic (EMT-P) applying for Continuous Accreditation and/or the Mobile Intensive Care Nurse (MICN) applying for Continuous Certification or Inactive MICN status within the ICEMA Region. The Annual Review Class is developed by a multidisciplinary task-force and the curriculum approved by the ICEMA Medical Director.

PROCEDURE

1. The authorized class is valid from January 1 through December 31 of each year. This protocol will apply to those individuals with expiration dates after Jan 31, 2007.
2. It is the responsibility of the individual to take the class during each year of accreditation or certification.
3. Failure to take an Annual Review Class during each year of accreditation or certification will result in the EMT-P or MICN having to successfully pass the ICEMA EMT-P Accreditation/MICN Certification Written Exam with a minimum score of eighty percent (80%).
4. The EMT-P or MICN must register and pay the exam fee to ICEMA prior to the scheduled deadline.

CRITERIA FOR TEACHING THE ANNUAL REVIEW CLASS

1. Approved C.E. providers shall request approval from ICEMA to provide the class:
   a. Submit a completed application to be approved as a training program
   b. Application must include a list of your proposed trainers with copies of their resumes attached
   c. Pay the ICEMA approved Training Program approval fee
   d. Approval is granted for a period of one (1) year
2. ICEMA should be notified thirty (30) days in advance of the class offering in order to be able to post the class dates, times and locations on the ICEMA website and newsletter.
3. Within fifteen (15) days of class completion, the provider will send the original C.E. roster to ICEMA with the Instructor Evaluation and any other material requested. All other course materials and records will be maintained, for a period of four (4) years, by the approved training program per Protocol Reference #14011 Policy for CE Provider Approval.
4. Continuing Education hours will be granted for the class within accordance to Protocol Reference # 14011 Continuing Education Provider.

APPROVED:

ICEMA Medical Director — Date

San Bernardino Co. Health Officer — Date: MAR 0 8 2006

Inyo Co. Health Officer — Date: 3/16/06

Mono Co. Health Officer — Date: 3/21/06

ICEMA Executive Director — Date: 3/23/06

CONTINUING EDUCATION PROVIDER POLICY

PURPOSE

This policy will define the requirements for Continuing Education (CE) Providers within the ICEMA Region.

AUTHORITY

California Code of Regulations, Title 22, Division 9, Chapter 11 EMS Continuing Education

DEFINITIONS

Emergency Medical Services (EMS) Continuing Education (CE) Provider: An individual or organization approved by the requirements of Title 22, Division 9, Chapter 11, to conduct continuing education courses, classes activities or experiences and to issue earned continuing education hours to EMS Personnel for the purpose of maintaining certification/licensure or re-establishing lapsed certification or licensure.

Clinical Director: A person currently licensed as a physician, registered nurse, physician assistant, or paramedic. The clinical director shall have had two years of academic, administrative or clinical experience in Emergency Medicine or EMS care within the last five years. The clinical director shall be responsible for monitoring all clinical and field activities approved for CE credit, approving instructors, and monitoring the overall quality of the EMS content of the program.

Continuing Education: A course, class, activity, or experience designed to be educational in nature, with learning objectives and performance evaluations for the purpose of providing EMS personnel with reinforcement of basic EMS training as well as knowledge to enhance individual and system proficiency in the practice of pre-hospital emergency medical care.

Instructor: A person approved by the program director and clinical director as qualified to teach the topics assigned, or have evidence of specialized training which may include, but is not limited to, a certificate of training or an advanced degree in a given subject area, or have at least one year of experience within the last two years in the specialized area in which they are teaching or be knowledgeable, skillful and current in the subject matter of the course, class or activity.

Program Director: A person qualified by education and experience in methods, materials and evaluation of instruction, which shall be documented by at least forty hours in teaching methodology. The program director will administer the CE program, ensure adherence to all state regulations, local policies, approve course content and assign course hours to any sponsored CE program per State regulations

PROCEDURE

1. To become an approved CE provider, an organization or individual shall submit an application packet at least sixty days prior to the date of the first educational activity. The application packet shall include:
   a. Name and address of the applicant;
   b. Name of the program director, program clinical director, and contact person, if other than the program director or clinical director;
   c. The type of organization requesting approval;

d. The resumes of the program director and the clinical director; and,
e. The ICEMA approved fee

2. The applicant will be notified within fourteen working days that his/her request was received and will be informed as to what information, if any is missing.
3. The request will be approved or disapproved by ICEMA within sixty calendar days of receipt of the completed request.
4. If the request is approved, an EMS CE provider number will be issued for four years.
5. When the request is approved, the EMS CE provider shall follow all of the requirements of the California Code of Regulations Title 22, Division 9, Chapter 11.
6. If the application is not approved, the application may be resubmitted, in accordance with established procedures, when all deficiencies are corrected.

MAINTAINING RECORDS

1. All records will be maintained by the CE provider for four years, and shall include:
   a. Complete outlines for each course given, including a brief overview, instructional objectives, comprehensive topical outline, method of evaluation and a record of participant performance.
   b. Record of time, place, date each course is given and the number of CE hours granted.
   c. A resume for each instructor.
   d. An ICEMA approved roster signed by course participants to include name and license number of the individual taking any approved course and a record of any certificates issued.
2. Each CE provider will notify ICEMA within thirty calendar days of any changes in name, address, telephone number, program director, clinical director or contact person.
3. All records shall be made available to ICEMA upon request.
4. Copies of class rosters shall be sent to the ICEMA ALS /Training Coordinator within fifteen days of class completion.
5. The Clinical Director shall submit a complete list of courses with the number of individuals attending each course on a monthly basis to ICEMA on the ICEMA approved form.
6. It is the responsibility of the CE provider to submit an application for renewal with the ICEMA approved fee, at least sixty calendar days before the expiration date in order to maintain continuous approval.
7. All CE provider requirements required by State legislation must be met and maintained.

POLICY

1. When two or more CE providers co-sponsor a course, only one approved provider number will be used for that course, class or activity and that CE provider assumes the responsibility for all applicable provisions of Chapter 11 EMS Continuing Education.
2. The State EMS Authority shall be the agency responsible for approving CE providers for statewide public safety agencies and CE providers whose headquarters are located out-of-state if not approved by the Continuing Education Board for Emergency Medical Services (CECBEMS) or approved by the EMS offices of other states or courses in physical, social or behavioral sciences offered by accredited colleges and universities.
3. An approved CE provider may sponsor an organization or individual located within California that wishes to provide a single activity or course. The CE provider shall be responsible for ensuring the course meets all requirements and shall serve as the CE provider of record. The CE provider shall review the request to ensure that the course/activity complies with the minimum requirements.

APPROVED:

EMS Medical Director Date

Inyo Co. Health Officer Date

San Bernardino Co. Health Officer Date

Mono Co. Health Officer Date

ICEMA Executive Director Date

INLAND COUNTIES EMERGENCY MEDICAL AGENCY
Serving San Bernardino, Inyo, and Mono Counties
515 N ARROWHEAD AVENUE
SAN BERNARDINO, CA 92415-0060
909-388-5823 FAX: 909-388-5825

APPROVED CONTINUING EDUCATION CLASS ROSTER

Course Title: _____

Course Location: _____

Principal Instructor: _____ _____
Date

Provider Name: _____ _____
Phone

TO INSURE CONTINUING EDUCATION CREDIT, THE INFORMATION BELOW SHALL BE CORRECT AND LEGIBLE

Name	State EMT-P RN License#	Local Accreditation/ Certification#	Name	State EMT-P RN License#	Local Accreditation/ Certification#

_____ _____
Signature of Instructor Title

_____ _____
Signature of Program Director Date

This course has been approved for _____ hours of continuing education by an approved California EMS CE Provider and was (check one) ___ instructor- based,___ non-instructor based. This document must be retained for a period of four years. California EMS CE Provider, #62-_____

The Provider must send a copy of this roster to ICEMA within fifteen (15) days after the course was given.

INLAND COUNTIES EMERGENCY MEDICAL AGENCY
Serving San Bernardino, Inyo, and Mono Counties
515 North Arrowhead Ave.
San Bernardino, CA 92415-0060
909-388-5823 FAX: 909-388-5825

MONTHLY CONTINUING EDUCATION CLASS LOG

CE Provider Name:

CE Provider Number:

Month:

Date	Name of Class	Number Attending
Totals		

The provider shall submit this form by the tenth (10) of every month per Protocol Reference #14011

TO INSURE CONTINUING EDUCATION CREDIT, THE INFORMATION BELOW SHALL BE CORRECT AND LEGIBLE

Name	**State EMT-P RN License#**	**Local Accreditation/ Certification#**	**Name**	**State EMT-P RN License#**	**Local Accreditation/ Certification#**

CE02_CONTINUINGEDUCATIONCLASSROSTER:11/04

REQUIREMENTS FOR THE INITIATION, COMPLETION, REVIEW, AND RETENTION OF RECORDS

PURPOSE

To delineate requirements within the ICEMA region regarding the initiation, completion, review, and retention of patient care report forms.

AUTHORITY

Title 22, California Administrative Code, Sections 1000168(6) (A-D) and 100085(6) (f).

PRINCIPLE

The patient care report form in the ICEMA region shall be comprised of a narrative patient care report form (ICEMA approved patient care report form or approved electronic Patient Care Report) and an ICEMA approved data collection device. They will be initiated each time an EMS unit is dispatched by an EMS service provider, where the outcome of the call results in patient assessment with or without service or treatment by the EMS provider.

In situations where more than one patient is encountered at the scene of an incident, one set of patient care record forms shall be initiated for each patient.

In the event that two EMS provider agencies arrive on scene at an incident, each EMS provider having actual contact with a patient is responsible for completing a patient care report form and obtain all ICEMA required data containing an incident number and patient identification information and record those assessments, services, or treatments delivered by the EMS provider completing that form. Thus, a patient receiving initial BLS level service followed by ALS treatment by another provider agency would have two sets of EMS forms.

RESPONSIBILITIES FOR RECORD COMPLETION

Each set of EMS patient care record forms shall be completed as specified in the 'EMS Run Report Form Completion Instructions", which serves as an extension to this policy. Each EMS patient care provider is responsible for proper completion of patient care records. Additional responsibility for accurate and thorough completion of patient care records lies with the EMS provider agency.

EMS providers who fail to thoroughly complete patient care records according to this policy will be given an opportunity to correct errors and/or omissions, following EMS review of the form as initially submitted.

In the event that addition(s) are required to a narrative patient care record form after submission of that form to the receiving hospital, a separate, new narrative patient care record form must be completed in full with one copy forwarded to the receiving hospital and one copy to EMS. Correction(s) to a Scantron form are to be made on the original Data Sheet whenever possible, and corrected Data Sheets sent to EMS in batches clearly marked as "corrections".

RESPONSIBILITIES FOR RECORD RETENTION

Requirements

1. All records related to either suspected or pending litigation shall be held for an indefinite period of time.

2. The patient care records of all patients other than un-emancipated minors shall be retained by the respective agencies for a minimum of seven (7) years.
3. The records of un-emancipated minors shall be kept for at least one (1) year after such minors have reached the age of 18, but in no event less than seven (7) years following the provision of service to the minor.
4. All receiving hospital copies of the patient care record form shall accompany the patient to the receiving hospital and be retained by the receiving hospital for a minimum of one (1) year in the patient's medical record
5. The EMS service provider agency shall be responsible for retention of the provider copy of the patient care record form.

Types of Records for Retention

The Base Hospital information form for each Base Hospital advanced life support radio contact

Labeled tapes (not transcriptions) or other type hard copies of communications between advanced life support personnel and the Base Hospital physician and/or MICN

Chronological log of each Base Hospital advanced life support radio contact

Patient care records

RESPONSIBILITIES FOR RECORD REVIEW AND EVALUATION

ICEMA may request a copy of any completed patient care record form. Responsibility for timely submission of requested forms lies with the EMS service provider agency.

Designated ICEMA staff shall be responsible for reviewing all completed patient care record forms submitted to ICEMA. Such review shall include, but not be limited to, procedures to determine the completeness of forms, methods to collect data recorded on the EMS copies of forms, and processing to produce statistical and quality assurance summary reports.

Evaluation of statistical summary reports shall be the responsibility of the ICEMA Executive Director. Evaluation of medical quality assurance summary reports shall be the responsibility of the ICEMA Medical Director. Copies of statistical summary and QA summary reports will be provided to provider agencies upon request.

APPROVED:

ICEMA Medical Director 2-28-06 Date

San Bernardino Co. Health Officer MAR 0 8 2006 Date

Inyo Co. Health Officer James Richardson MD 3/16/06 Date

Mono Co. Health Officer 3/24/06 Date

ICEMA Executive Director Virginia Hastings 3/23/06 Date

EMERGENCY CALLS
EMT-P'S must completely fill out a 01A form for every emergency call where patient contact is made.
Exceptions are as follows:

1. Weight may be left blank if not used for treatment;
2. Mechanisms of injury should be blank for non trauma patients;
3. Zones may be blank if not applicable to the local area;
4. EKG rhythm should be blank if no EKG is done.

INTERFACILITY TRANSFERS
For reporting purposes, an "interfacility transfer" is a call on which a patient is transported from a hospital to another health care facility or other location. This includes calls on which they took a patient from a hospital to a nursing home (or vice versa); from a hospital to the patient's home; or from a hospital to another hospital. **ALS interfacility transfers (paramedic on the unit) require both a 01A Narrative form and a F-1612 data form.**

The following 01A Form items are to be completed for all ALS interfacility transfers:
1. patient name, home address and zip code
2. patient age and sex
3. chief complaint
4. blood pressure, respiration rates, respiratory efforts, capillary refill, eye opening
5. verbal response, motor response
6. head-to-toe physical assessment
7. care rendered (if any), response to treatment rendered and time administered
8. incident number
9. run dates
10. unit number
11. location (address of facility where patient is picked up)
12. times call for transport received
13. time dispatched (en route)
14. time of arrival at transferring hospitals
15. time departed a transferring hospital
16. time arrived at destination facility
17. receiving hospitals (or facility) code (for location to which patient transferred)
18. attendant signatures(s)
19. signature of person receiving the patient at the destination facility

CANCELED CALLS
A call is considered "canceled en route" when the dispatcher notifies the unit that they have canceled before the unit arrives on scene; that is, **before they make patient contact**. A **01A FORM IS NOT REQUIRED for a call that is canceled enroute**. We recommend that provider agencies use a form for data collection (for example, a dispatch report form) that contains, at a minimum, the following information:

1. incident number
2. run dates
3. incident cities
4. time call received
5. time en route to the scene
6. run code to the scene
7. call outcomes ("canceled en route")
8. attendant certification number(s)
9. provider and unit number

DRY RUNS
For reporting purposes, a "dry run" is a call on which **no patient contact is made at the scene. A 01A FORM IS NOT REQUIRED FOR THIS TYPE OF RUN.** However, if patient contact is made, and the patient refuses treatment or transport, an O1A form is required. For dry runs with no patient contact, provider agencies may use an alternative method of data collection of their choice that contains, at a minimum, the following data:

1. incident number
2. run dates
3. incident cities
4. time call received
5. time en route to the scene
6. run code to the scene
7. Call outcomes ("dry run-no pt.")
8. attendant certification number(s)
9. provider and unit number

DETAILS FOR COMPLETING THE PCR 01A NARRATIVE FORM

CANCELED ~ AMA ~ TRANSPORT ~ AIR
Mark the appropriate box for the run.

ICEMA NUMBER
The preprinted ICEMA number is located at the upper left corner of the 01A Narrative form. Mark this number on the corresponding F-1612 data form in the spaces provided for "ICEMA #" (central bottom portions of the data form).

PRIM. INC. #
Obtain this number from the dispatcher, normally after completion of the call. This is the incident (dispatch) number of the provider agency that sends the unit to the scene. Write the number in the space shown.

OTHER PROVIDER
Document the transporting agency's abbreviated name and the unit number of the vehicle when you transfer patient care to another provider for transport.

DATE
Write the date on which the provider agency received the call. Use a six-digit number. For example, enter 06/01/02 for June 1, 2002.

UNIT
This space is for the unit number (as assigned by the provider agency) of the vehicle that responded to the incident.

LOCATION OF CALL
Write the location of the incident as supplied by the agency dispatcher. Record the street number and street name when available. If they do not provide these items, record the cross streets and nearest city or community. Do not write "home" or "same."

CITY
Write the name of the city where the incident occurred. Use this to decide the city code entered on the F-1612 data form.

ZONE
Use this space to record the State Fire Marshall's fire demand zone number or the zone within a city designated by an EMS provider agency. ICEMA does not require the zone, use at the discretion of the provider agency.

NAME ~ ADDRESS ~ CITY ~ STATE ~ ZIP
Write in the patient's full name (first name, middle initial if any, and last name) on the line provided near the top of the form. Write the patient's street address, mailing address if different, the city where the patient resides, two-letter postal abbreviations for the state, and zip code on the second blank line. While on scene, and the patient is in a life-threatening situation or unable to provide an address, obtain the information from hospital personnel at the receiving hospital.

PHONE
Record telephone number to include area code.

SOCIAL SECURITY NUMBER
Enter nine-digit number.

AGE
After identifying the patient at the scene and inquiring about his or her age, record the age in years in the space shown.

DOB
Record the patient's date of birth in 6-digit format, for example, 01/01/02.

M/F
Record the patient's sex. Check the box before "M" for male, or "F" for female.

APPROX. WEIGHT
For all pediatric patients, write the patient's weight, in kilograms, in the space provided. For adults, record the weight only if necessary to treatment (for example, if drug dosage for patient condition depends upon body weight).

APPROX. HEIGHT
For all pediatric patients, record the patient's height, in feet and inches, in the space provided. For adults, record height only if weight is also necessary.

PT __ OF __
Enter assigned patient number out of total number of patients transported.

CARE PRIOR TO ARRIVAL
Check the appropriate box for the type of emergency care given prior to your unit's arrival.

1. None: No prior care.
2. CPR: If started prior to your arrival on scene
3. Other BLS: Any procedure listed in the Care Rendered-left column on the F-1612 data form.
4. ALS: Any procedure listed in the Care Rendered-right column on the F-1612 data form.

PRIOR CARE GIVER
Mark the appropriate box to show the type of agency/individual providing care prior to your unit's arrival on the scene.

1. CITZ.: a citizen, bystander, or relative provided care.
2. None: no prior caregiver.
3. Medical: physician, nurse, first responders, ski patrol, or other trained medical person on a scene provided prior care.
4. FD/BLS: a BLS unit provided prior care.
5. Law Enforce: police, sheriff, or other law enforcement personnel provided care.
6. FD/ALS: a non-transporting ALS unit provided prior care.
7. ALS Amb: ALS ambulance personnel provided prior care.

RECEIVED
Time call is first received by EMS Provider Agency. This time may be received from the dispatcher after completion of the call. Write the time, in hours and minutes, using military time (a 24-hour clock) in the box provided. Valid times range from zero (midnight) to 2359 (11:59 p.m.). **Do NOT use 2400. Note**: For walk-in patients, the time call received is when the patient walks in the door; depart is when the patient leaves; and all other times are blank.

EN ROUTE
Time that the response unit begins physical motion; i.e. wheels begin to turn.

ARRIVE
Time the EMS unit stops physical motion at scene on staging area; i.e. wheels stop turning. (Last place that the unit vehicle stops prior to assessing the patient.)

PT. CONTACT
Time response personnel establish direct contact with patient.

DEPART
Time when the response unit begins physical motion from scene, i.e. when the wheels begin to turn. If you transport a patient, record DEPART as the time the ambulance leaves the scene enroute to the hospital or other destination. If the unit completing the run is not transporting the patient, record DEPART as the time when the unit is available for another call. If the patient refuses transport, record DEPART time as the time that you leave scene.

ARRIV. DEST/END CALL
Time when patient arrives at destination or transfer point, i.e. wheels stop turning. Leave blank if your unit is not transporting the patient. Note**: Time call ended; i.e. AMA, the time a non-transport provider transferred care to a transport provider.**

AVAILABLE
Record the time that the unit is back in service and available for another call, whether they transported the patient or not.

CODE EN ROUTE
Circle the number that corresponds to the definitions below by which the unit responded to the incident:

(1) Non-Emergent, no lights or sirens
(2) Urgent, obeying all traffic regulations, no lights or sirens
(3) Emergent, with lights and sirens

CODE DEPART
Circle the number that corresponds to the mode of transportation the ambulance utilized enroute to the hospital (1, 2, or 3, as described above). If transportation does not occur, leave this item blank.

ODOMETER
Use this section as directed by your employer. ICEMA does not require odometer readings.

FAC. CONTACTED
Write an abbreviation for the base hospital contacted on this call. If the unit never attempted to make voice contact with the Base Hospital, write "none." If the Base Hospital was successfully contacted, mark the type of instrument/frequency utilized:

1. BH: Base Hospital
2. VHF: EMS/HEAR radio
3. UHF: Bio-com
4. Phone: Land line telephones
5. CELL: Cell phone
6. 800Mhz: San Bernardino County system
7. None: In Radio Communication failure record the BH name

CONTACT TIME
Record the time contact was initiated with the base hospital.

RECEIVING HOSPITAL
Record the name or appropriate abbreviation for the hospital where the patient was transported.

Mark the ONE category that best describes the reason for selection of the receiving hospital:

Pt. Request:	patient or patient's physician requested this facility
Diversion:	the original receiving hospital selected was on diversion for this type of call
Trauma:	transported to this facility because they require a trauma center
RCF:	radio communication failure
Peds trauma:	they require a pediatric trauma center
Reroute:	the receiving hospital destination changed while the unit was en route from scene. E.g., a change in patient condition required selection of a different facility). Not to include change in the destination based upon hospital status (see "diversion")
Closest:	the hospital is selected because it is closest to the scene
Other:	a reason other than those listed above in selecting the receiving hospital

CHIEF COMPLAINT
Use the blank space under this heading to describe details of the patient's problem. Describe the location of injury; (head, face, neck, chest, abdomen, rt. or lt. arm or leg, rt. or lt. hand or foot), or sites of pain; the type of injury or pain (e.g., fracture, laceration, etc.), and other medically relevant signs and symptoms (e.g., estimated blood loss). Include drug or alcohol use here.

MECHANISM OF INJURY
For all trauma patients, record the reported cause of injury. Categories include motor vehicle accidents (MVA), motorcycle collisions (MCA), GSW, stabbing etc. For falls, specify if more than 20 feet. Show whether injury is blunt or penetrating. If undeterminable, write "unknown." Circle “Y”-yes or “N”-no to the following questions; did the patient wear a helmet, a seat belt, have a loss of consciousness (LOC), and was an airbag inflated?

MED. HISTORY
Use this space to record the patient’s medical history. History may include cardiac, respiratory, liver, kidney, or other known disease, any recent and/or related illnesses, medical conditions, hospitalizations, history of trauma, or medical treatments. Also, record the time of injury or time of onset of symptoms as stated by the patient. Check appropriate predesignated diagnosis if one applies to the patient.

MEDICATION
Write the names of all prescription or over-the-counter medications the patient is currently taking. Abbreviate as necessary. If they do not know the specific name of the drug, record the class of drug or the action it takes (e.g., insulin, diuretic, an antidepressant, antihistamine, etc.). Include dose and frequency if it is taken daily (e.g., Bid, T.i.d., QD). Bring any medication not quickly identifiable to the hospital with the patient.

ALLERGIES
Mark the box ‘NKA’ for no known allergies. Otherwise, record the names of any medications to which the patient has had an allergic reaction. Also record any other allergies either related to the current problem (for example, the mechanism of injury is "bite/sting" and the patient is allergic to bee stings), or environmental allergies (for example Latex allergies).

BLOOD PRESSURE
Record the time (use a 24-hour clock) and initial blood pressure reading as systolic/diastolic. Note if auscultation or palpation was used to obtain B/P. Record blood pressure readings as required by protocol. If you require additional space, use the Narrative section.

PULSE
Record the rate and quality of the pulse (e.g., thready, bounding, irregular). Use appropriate abbreviations (e.g., 70 norm., 60 irreg.). Record repeated pulse rate and quality as required by protocol. Use the Narrative section for additional space, if required.

RESPIRATION
Record the rate, number of respiration's per minute/quality of respiration's (e.g., clear, wheezes, rales, unequal, or absent). Record repeated respiratory rate and quality as required by protocol. Describe lung sounds as auscultated with a stethoscope. Use the Narrative section for additional space, if required.

PULSE OX
Give numeric value as a percentile and whether it was taken on room air or with supplemental oxygen.

SKIN COLOR
Mark the category that most closely matches the patient's skin color upon initial assessment: normal, pale/ashen, cyanotic, or flushed. Check box "A" for first time observed and box "B" where a vital sign is repeated record time for "A" and time "B" in line provided.

MOISTURE
Mark how much skin moisture noted on initial assessment: normal, dry, moist, or profusely diaphoretic.

SKIN TEMP
Mark the patient's skin temperature as noted on initial assessment: hot, warm, cool, or cold.

PUPILS - LT (LEFT) RT (RIGHT)
Mark the boxes that best describes the pupillary response or status upon initial assessment of the patient. Separate columns are provided for description of pupillary response in left and right eyes.

RESPIRATORY EFF.
Record the patient's visible respiratory effort (chest wall movement), mark the box next to the category that better describes the present condition for this patient--normal, or abnormal (shallow/retractive/none).

1. Normal: easy, unlabored, deep respirations.
2. Shallow: diminished volume of respirations.
3. Retractive: this involves the use of the accessory and/or abdominal muscles for breathing.
4. None: mark if patient has no apparent respirations.

If no box is marked, it will be assumed that no assessment was done.

CAPILLARY REFILL
Mark the box next to the category that best describes the patient's capillary refill upon assessment.

1. Immediate: return of color in two seconds or less.
2. Delayed: color does not return in less than two seconds
3. None: no return of color.

EYE OPENING
Note the patient's initial ability to open his/her eye(s). Mark the box next to the appropriate category.

1. Spontaneous: patients' eyes open without stimulation; patient can close eyes upon request.
2. To voice: eyes open when the patient's name is spoken or shouted.
3. To pain: eyes open in response to a standard pain stimulus.
4. None: eyes do not open despite a stimulus.

VERBAL RESPONSE
Mark the box next to the category that describes this patient's initial best verbal response.

1. Oriented: correctly responds when asked name, place, date, and history of an event.
2. Confused: incorrectly responds to questions, but can produce phrases of more than two
3. Inappropriate: able to produce only an intact word or two in response to physical stimulation.
4. Incomprehensible: able to produce sounds (mumbling or groaning), but no words.
5. None: no verbal response to any stimulation.

MOTOR RESPONSE
Mark the box next to the patient's initial best motor response.

1. Obedient: Pt. ability to comprehend, physically execute a spoken or written instruction.
2. Purposeful: patient responds to a standard pain stimulus.
3. Withdrawal: no verbal response; the elbows flex rapidly with no muscle stiffness.
4. Flexion: no verbal response; the elbows flex slowly and muscle is stiff.
5. Extension: no verbal response; arms and/or legs out; muscles are stiff.
6. None: no verbal or motor response.

PULSE
Mark the box next to the appropriate area (Femoral, Radial, Carotid) as present or absent.

GCS
Enter the GCS (Glasgow Coma Scale) and include in report to base hospital.

PT PHYSICIAN
Enter name of patients' physicians, if known.

TEMP
Enter patients' body temperature and location taken (oral, tympanic).

BLOOD GLUCOSE D50/D25
Enter blood glucose numeric value before D50/D25 was given and enter a secondary numeric value for the repeat blood glucose after the administration of D50/D25.

END-TIDAL Co2 DETECTED
If the patient is intubated, note detection of Co2 after placement, before the patient is moved and after moving patient.

SECONDARY SURVEY
Mark the box for the appropriate category in each section of the "**neuro/head**" survey.

WNL: within normal limits.
N/A: not applicable.
ABN: abnormal.

In the comments section next to "**neck**", mark box if no JVD (jugular venous distention); next to "**chest**", mark if negative barrel hoop; next to "**abdomen**", mark if soft and/supple; next to "**back-spine**", mark if full spinal immobilization was instituted (this constitutes rigid collar, head/chin straps, head bed, long board and straps); next to "**pelvis**", mark box if negative or no instability noticed; next to "**extreme**", mark box if no distal edema and if the patient has full range of motion.

NARCOTIC GIVEN ~ NARCOTIC WASTED
Enter the amount of the narcotic given to patient. Enter the amount, date, time, and location where narcotic was wasted. The EMT-P and the Nurse who witnessed the waste of the narcotic must sign in the appropriate area.

EKG - DEFIB RHYTHM
When an EMS field provider places a patient on the monitor, this area must be completed. Do not record a rhythm obtained by another unit. Record the initial and any subsequent rhythms in the spaces provided. Enter energy level in joules if patient is cardioverted or defibrillated, and rhythm following procedure. If TCP is utilized note capture, rate and amperes used. If additional space is needed, continue in the Narrative/Assessment section.

CARE RENDERED
Record the time that any medication or procedure was ordered or initiated by the EMT/Paramedic, using the 24-hour clock format. Identify medications and procedures prior to Base Hospital contact with the abbreviation "PTC" immediately following the time. **Be sure to include all types of treatment in this section. Record only those treatments provided by attendants signing this form.** Record the time when each procedure was initiated. Include RT/Size-route and size of appliance used, dose and response to treatment in sections provided. Record the complete name of all drugs administered, with the time ordered, route, dose, and time administered. Use abbreviations as necessary. If the Base Hospital ordered, medications or procedures but where not completed please note that fact in this section

PQRST
Record in the PQRST box as applicable.

"P" Provoke-what provoked pain?
"Q" Quality of pain-sharp/dull?
"R" Radiate-where does the pain radiate?
"S" Severity-have the patient rate on a 1-10 scale how severe they feel the pain is, one being the least pain they've experienced and 10 being the worst.
"T" Time-how long have they had the pain?

NARRATIVE/ASSESSMENT
Use this section for details concerning the patient. Include exceptions and unusual conditions or circumstances. Record the type of care administered prior to arrival of this unit. Overall change (or no change) in patient condition. Do not record personal opinions. Note pertinent negatives in physical assessment and response or change after care rendered. Use **ICEMA Supplemental Patient Report** form if more space is needed.

3 TEAM MEMBER SIGNATURE AREAS
This area is for the name and Accreditation/Certification number of the team members. Mark the appropriate box for each team member.

1. Patient Attendant: The team member responsible for patient care.
2. Radio Attendant: The team member who made contact with the Base Hospital.
3. Completed form: The team member who actually completed the O1A form.
4. Other: Mark this box if there is a third member (trainee or ride out).

FORM NOT COMPLETED ON SCENE
Mark this box when the O1A form is not completed on scene.

PT RECEIVED BY
The physician or nurse taking responsibility for the patient must sign this area upon arrival at the receiving hospital or facility. When an air ambulance takes a patient from a ground ambulance for further transport, the person on the air transport crew will sign here. They now assume responsibility for patient care. The ground ambulance gives the second green copy of the form to the person whose signature appears in this area.

REVERSE SIDES OF FORM
The reverse sides of the original and three copies of the 01A Narrative form contain additional printed information. When filling out the reverse sides remember to write only on the form you are using.

BACK OF FIRST (WHITE) COPY

BILLING INFORMATION
This is the provider's copy. Complete this section as directed by your employer. ICEMA does not require completion of billing information.

MEDICAL/LIABILITY RELEASE FORM
If the patient refuses treatment, have the patient complete the "Medical Liability Release Form" on the back of the first copy (white) of the 01A Narrative form. If the patient is a minor, also have the parent or guardians sign the release. Sign the release in the area for Witness 1, and obtain the signature of a second witness. If Base Hospital contact was made, mark the box next to "Yes" on the bottom of the release; otherwise, mark "No". Document in the Narrative all pertinent information regarding the incident.

PHYSICIAN'S RESPONSIBILITY
If a physician on scene states a desire to take charge of the patient, he or she must show a current California Medical Physician's License. The doctor must read the "Physician's Responsibility" statement on the back of the first copy (white) of the 01A form and must sign the form, including his or her license number and expiration date. Make Base Hospital contact and state that a physician is on scene requesting to take medical control of the patient. **If the Base Hospital physician agrees to relinquish control** you may perform any procedure or give any medication approved for use in the ICEMA region under the direction of the physician on scene. This physician must accompany the patient to the receiving facility in the ambulance. The field provider must complete the 01A form as usual.

BACK OF SECOND (GREEN) COPY

THROMBOLYTIC ASSESSMENT
This checklist should be completed while enroute on all chest pain patients. This information should be conveyed to the Base Hospital as soon as possible.

BASE HOSPITAL/RECEIVING FACILITY
These codes are to be used to identify the Base Hospital/Receiving Facility

RULE OF NINES CHART
This chart is included to assist the provider in determining burn percentages for the adult and pediatric patient.

APGAR SCORING
This chart is available for use in assessment of the newborn infant.

STANDARDIZED ABBREVIATIONS
These should be used consistently throughout the completion of the form. If an abbreviation is questionable, completely spell out the word so it is clear and concise to any individual reading the form.

BACK OF THIRD (YELLOW) COPY
This completed form must be given to the Base Hospital PLN; if patient is transported there, OR given to your QI/EMS Coordinator if patient transported to another facility. Complete for evaluation of the advanced skills: Adult Endotracheal Intubation, Pediatric Endotracheal Intubation, Nasotracheal Intubation, Percutaneous Needle Cricothyrotomy, Intraosseous Infusion, Transcutaneous Cardiac Pacing.

1. In space provided **record the patient's name** as written on the original 01A form.
2. Record the ICEMA run report number in space provided from the front of the 01A form.
3. Check all the procedures utilized in the boxes provided.

INTUBATION
Check the box provided for an adult or pediatric patient. Then mark the route used, (nasal or oral). Enter size of ET tube, number of attempts made and yes or no to if the procedure was successful.

NEEDLE CRICOTHYROTOMY
Enter the size of the needle, or name of the approved device, number of attempts, and if the procedure was successful.

INTRAOSSEOUS INFUSION
State the size of the IO catheter, number of attempts, and if the procedure was successful.

PLACEMENT VERIFIED
Document how you verified proper placement of device/procedure.

TRANSCUTANEOUS CARDIAC PACING
Document if the transcutaneous pacer captured the rhythm:

1. HR — The rate at which the pacemaker captured.
2. AMP — The amplitude needed to capture.
3. Palpable pulse rate — The palpated HR in beats per minute.
4. B/P — Blood pressure after pacing achieved.
5. Atropine given — Yes or No.

PULSE OXIMETRY
Record numeric value in a percentage of O2 present before treatment and after treatment.

END TIDAL CO2
Record if detected-yes or no, and percentage detected.

IF THE PROCEDURE YOU USED WAS SUCCESSFUL
Explain in the narrative the patient's response to treatment.

IF THE PROCEDURE YOU USED WAS UNSUCCESSFUL
Explain in the narrative what you felt inhibited the procedure from being successful (e.g., irreg. Anatomical structure, broken equipment, incorrect placement, etc.).

FIELD ASSESSMENT/TREATMENT INDICATORS
Document all the patient indicators for the procedure performed.

PROCEDURE PERFORMED
Document how procedure was performed: prior to contact, in radio communication failure (RCF), or upon base hospital order.

OTHER DOCUMENTATION
Document the name of the Receiving Facility, and/or the Base Hospital. Have receiving hospital physician sign the form in the space provided. The paramedic who completed the skill and the evaluation form signs the form in the space provided. The paramedic must give this form to the PLN at the contacted Base Hospital for review if the patient was transported to that facility or to their QI/EMS Coordinator if patient was transported to another facility.

PLN DOCUMENTATION
This area needs to be completed by either the PLN or QI/EMS Coordinator and sent to the ICEMA ALS Coordinator with a photocopy of both sides of the 01A form on a monthly basis.

BACK OF FOURTH (PINK) COPY

MULTIPLE PATIENT TRIAGE FORM
This area is provided to assist with multiple casualty incidents. This form is to help the team members with rapid patient assessment and organization. **Each patient requires a separate 01A Form and F-1612 data form**.

PATIENT TRANSPORTATION RECORD/MCI WORK SHEET
This is a work sheet provided to assist the paramedic with keeping track of where multiple patients are transported during a MCI. For each patient, enter:

1. name of the transporting agency
2. patient's triage tag number
3. approximate age and sex (M or F)
4. patient's triage priority status; "**I**" for immediate, "**D**" for delayed, or "**M**" for minor

Enter a brief description for chief complaint, and ETA in minutes from scene departure to arrival at receiving hospital. Record "Off Scene Time" as the time the transporting unit leaves the scene**. Following initial triage, complete a full set of Run Report Forms for each patient**. Information recorded on the multiple patient triage form can transfer to the front of the individual patient's 01A form.

INSTRUCTIONS FOR COMPLETING THE PCR F-1612 DATA COLLECTION FORM

MARKING THE FORM
The F-1612 data form is to be completed separately from the 01A form. Complete all marks on this form within the boxes or "bubbles" in ink, (any dark color except red) or a black pencil. Mark only designated boxes. No other marks or comment should appear. For optimal scanning, **do not fold, staple, paper clip, or bend this form.** The scanner will read any other writing, lines, or comments as data, even if intended as a line or comment. 'MONO Correction Tape', by TOMBOW, may be used to make corrections instantly cleanly completely and remark the error directly on film. This product is a timesaving option. White out correction fluid may also be used to correct marks made in error. Apply a thin coat; thick fluid jams the form in the scanner. In addition, use care not to white out any of the black marks along the left side of the form. Do not make any marks or let white out run in the lower left corner of the form (below "Outcome" and "Why Selected").

DISPOSITION OF FORM
Field providers will send completed F-1612 data forms to ICEMA for data processing and quality assurance review 30 days following the run date. Agencies using electronic data submission will also send their data 30 days following the run date.

WHEN TO COMPLETE A FORM
For every patient contact, including interfacility transfers, an F-1612 data form is required. If more than one patient is at the scene, a separate form must be completed for each patient. If two providers are dispatched to the same scene, each ALS provider who makes patient contact must complete an F-1612 data form. **Items recorded on the forms should reflect only those services provided by the person(s) completing the form.** For example, when one ALS unit arrives first on the scene, the paramedic would record all care rendered to the patient on their F-1612 data form. If another ALS provider takes over care, the second paramedic would record treatment performed by its personnel on a separate F-1612 data form and will write the ICEMA number of the form completed by the first ALS provider in the space for "Other ICEMA #."

EMERGENCY CALLS
For every emergency call where patient contact is made, all sections must be completed on the F-1612 data form. **Exceptions are as follows:**

1. Mechanisms of injury should be blank for non-trauma patients.
2. EKG rhythm should be blank if no EKG is done.
3. Medications administered should be left blank if no medications where given.

INTERFACILITY TRANSFERS
In addition to the 01A narrative form, the F-1612 data form must be completed for all ALS interfacility transfers. If a hospital request a BLS transfer but they send a paramedic on the run (with or without an EMT-I), an F-1612 data form is required. If the provider makes a BLS transfer with a nurse but no paramedic, we require only the 01A

form.

ALS interfacility transfers (paramedic on the unit) require both an F-1612 data form and a 01A Narrative form. The following F-1612 data form items are to be marked for ALS interfacility transfers:

1. patient sex, age, and zip code
2. number of patients
3. incident number
4. rundate (date transported)
5. city code (for the city where the transferring facility is located)
6. run code to the scene
7. category (marked "transfer")
8. receiving hospital code
9. times call for transport received
10. time enroute
11. time of arrival at transferring hospitals
12. time departed a transferring hospital
13. time arrived at destination facility
14. systolic BP, respiratory rate and effort, capillary refill, eye opening
15. verbal response, motor response
16. care rendered (ALS or BLS if any during transport)
17. response to treatment rendered and time administered
18. medications (Note: Medications that are being monitored, i.e. Magnesium Sulfate drips)
19. patient condition (change/no change enroute)
20. outcome
21. attendant accreditation/certification numbers
22. provider and unit codes

CANCELED CALLS

A call is considered “canceled enroute” when the dispatcher notifies the unit that they have canceled the call before the unit arrives on a scene or before patient contact is made.

The following F-1612 data form items are to be marked for calls canceled enroute:

1. incident number
2. run dates
3. incident city code
4. run code to the scene
5. time call received
6. time enroute to the scene
7. call outcomes ("canceled enroute")
8. attendant accreditation/certification number(s)
9. provider and unit numbers

DRY RUNS

For data collection a “dry run” is a call on which **no patient contact is made at the scene**. Although the 01A form is not required for this type of run, an F-1612 data form is required. If patient contact is made at the scene and refuses treatment or transport, the F1612 data form is still required.

The following F-1612 data form items are to be marked for dry runs:

1. incident number
2. run dates
3. incident city code
4. run code to the scene
5. time call received
6. time enroute to the scene
7. call outcomes (“dry run-no pt.”)
8. Attendant accreditation/certification number(s)
9. Provider and unit numbers

DETAILS FOR COMPLETING THE F-1612 PCR DATA COLLECTION FORM

The F-1612 data form should be completed as soon as possible after the call, while the details of the run are fresh in your mind. All marks on the form must appear within the "boxes." *Data recorded here must match corresponding items on the 01A Narrative form for the patient*. No extra comments or writing should appear on the F-1612 data form, as the scanner will read the data incorrectly.

SEX (*Fieldname: GENDER*)
To show the patient's gender, mark the appropriate box **(M)ale, (F)emale** or **(U)nknown** (if the sex cannot be determined). **Do not mark more than one box**. The scanner reads a mark in the box for "M" that extends into the next box for "F" as a question mark, causing an error in the data.

AGE
Mark two numbers, **(0-9)**. Mark the numbers under the heading "Age" that match the number of whole years in the patient's age. If the patient is less than one year old, mark two zeroes ("00"). If they state the patient's age as "18 months," mark ("01") in the numbers below "Age." If they state the patient's age in half-years, for example as "two and a half," record only the whole number of years (marking the numbers "02"). If the patient is more than 99 years old, mark two nines ("99"). When the patient is obviously dead, attempt to get age from another party at the scene who knows the patient, or estimate the patient's age.

ZIP
Mark the numbers **(0-9)** beneath the heading "Zip" that represent the **first five digits of the patient's zip code**. If the patient is homeless or in transition or for some other reason has no zip code, make no marks in this section. For patients from outside the United States, mark 99999.

#PTS (*Fieldname:* PTS)
Record the number of patients encountered under the heading "# Pts" by marking the box with the appropriate number **(0-9)**. If you encounter more than nine patients at the scene, mark the box for ">9". Both the 01A Narrative form and F-1612 data form must be completed for each patient. This item is used to count multi-casualty incidents for statistical reporting. For example, a three-victim motor vehicle accident would have three forms, with "Number patients" marked "3" on each form--three different ICEMA numbers, with one incident number.

INCIDENT #
Mark eight boxes **(0-9)**. Using the dispatch number recorded on the *01A narrative under "Prim. Inc. #,"* mark the corresponding numbers below the heading for "Incident #." If the incident number is less than eight digits, mark zeroes to fill the boxes to the left of the incident number.

RUNDATE (*Fieldnames:* RUN-YEAR1 (9,0,1)/RUN-YEAR2 (0-9)/RUN-MONTH (0-9)/RUN-DAY (0-9))
Mark six boxes. Mark the numbers below the heading "rundate" that match the date written *in the "Date" area of the 01A Narrative*. Use 6-digit format and marking zeroes as necessary for the month and day, year, e.g., 06/01/02.

CITY
Mark three boxes **(0-9)**. Refer to the Incident City Codes listed on the back of the F-1612 data form. Find the three-digit code number across from the name of the city where the incident occurred. Mark the numbers beneath the heading "City" that represent this three-digit city code.

RUN CODE (*Fieldnames:* RUN TO CODE/RUN FR CODE)

Definitions:

(1) Non-Emergent, no lights or sirens
(2) Urgent, obeying all traffic regulations, no lights or sirens
(3) Emergent, with lights and sirens

RUN TO CODE: Mark the number **(1, 2 or 3)** of run codes enroute to the scene. This should be the same number as that circled for *"Received Code" on the 01A Narrative*:

RUN FR CODE: Mark the number **(1, 2 or 3)** of run codes from the scene to the receiving. This should be the same number as circled for *"Depart Code" on the 01A Narrative*. If you make no transport, leave this item blank.

OTHER TRANSPORT PROVIDER/UNIT (*Fieldname*s: PROVIDER A/UNIT A)

Record the provider code **(0-9)** of another provider on scene. If your unit is the first on a scene and transfer patient care to another unit for transport, refer to the "Other Provider" area of the 01A Narrative. The transporting Provider Code list is on the back of the F-1612 data form. For fire departments, this code is "000." Record the 3-digit provider code and the unit number of the transporting unit. Complete this section only if a second unit is on scene and makes patient contact. **Use 777 for transport by any private car, truck, or other vehicle** that transports the patient (citizen transport). **Use 888 for transport by any provider that does not have an assigned code**, including transport by agencies outside the region.

TRANSP CODE1 (OTHER TRANSPORT)

Mark the type of unit **(MA, MS, ME, AM, SQ, E)** for another provider on scene. Enter this information only if a second unit is on scene and makes patient contact.

(MA)Medic Ambulance
(MS)Medic Squad
(ME)Medic Engine
(AM)Ambulance
(SQ)Squad
(E)Engine.

OTHER ICEMA# (*Fieldname:* ICEMA#1)

Enter another agency's O1A Narrative form number whenever another ALS provider agency is on scene and makes contact with the same patient. (*You mark their 01A number on your F-1612 data form, and they mark your 01A number on their F-1612 data form in the "Other ICEMA #" box*.) Fill this in whenever another 01A Narrative form exists for the same patient. If only one 01A form exists for a patient, this area should be blank.

PRIOR CARE

Mark the **one** appropriate box **(N, M, B, C, O, L, A)** to show the person or agent providing care or treatment to the patient prior to arrival of the prehospital field personnel completing this form.

1. **(N)none**: no care given to the patient prior to arrival of this unit.
2. **(M)medical**: a physician, nurse, or other medical person on a scene provided care.
3. **(B)FD/BLS**: a BLS unit provided prior care.
4. **(C)citizen**: a citizen, bystander, or relative provided care.
5. **(O)other**: Some person gave prior care not fitting any of the defined categories.
6. **(L)law enf.** police, sheriff, or other law enforcement personnel provided care.
7. **(A)FD/ALS**: another ALS unit provided prior care.

MECH. OF INJURY-TRAUMA ONLY (*Fieldname:* INJURY MECH)

Mark the space next to the **one** category **(M, C, G, S, A, D, F, B, L, T, P, O, U)** that best describes the mechanism of injury precipitating this call**. This section should be left blank for non-trauma cases**.

(M)auto/truck-MVA: any traffic incident, except those involving motorcycles. This includes an auto vs. an auto, auto vs. truck, pedestrian vs. autos, single vehicle collisions, etc.

SEATBELT: **(*Fieldname*)** **(Y)es or (N)o** to show if the patient was wearing a seatbelt or other safety restraint device. Must be completed for all motor vehicle accident calls.

(C)motorcycle: any traffic related incident involving a motorcycle or bicycle. This includes autos vs. motorcycle, motorcycle vs. pedestrian, bicycle vs pedestrian, etc.

HELMET: ***(Fieldname)***: **(Y)es or (N)o** to show if the patient was wearing a protective helmet. Must be completed for all traffic-related incidents involving motorcycles.

(G)gunshot: any call involving injury from a firearm, including a pistol, shotgun, rifle, or other similar weapon.

(S)stabbing: a penetrating injury by a knife or other sharp object.

(A)assault: any injury resulting from assault other than a gunshot wound or stabbing.

(D)near-drowning: conditions resulting from submersion that deprives the patient of oxygen.

(F)fall >20' : injury resulting from a fall from a building, ladder, or other place estimated at more than 20 feet from the area where the patient landed. Do not use this category for slips or short-distance falls such as a fall in the bathtub. **For short falls, mark "blunt injury" or "penetrating injury"** as appropriate.

(B)bite/sting: injury from any type of animal, insect bite or sting; e.g., snakes, bee, a dog bite.

(L)blunt injury: an accidental injury in which the skin is unbroken or only slightly opened.

(T)multiple mech.: more than one mechanism of injury none more notable than another. If more than one mechanism, but one dominant injury occurs with other minor injuries, check the single category that caused the dominant injury.

(P)oth penetrating: an injury other than stabbing which penetrates the skin and subcutaneous tissue.

(O)other: any condition not covered under the categories above, including ski, snow boarding, and boating accidents.

(U)unknown: the mechanism of injury cannot be determined.

CATEGORY

Mark the **one** box **(T, C, R, A, B, 5, U, D, E, O, P, S, M, N)** next to the category that best fits this patient.

(T)trauma: any serious traumatic condition except cranial and/or spinal injury, assault involving domestic violence, or amputation. If you mark this box, you must **also mark "MECH. OF INJURY."** For **ski accidents**, mark this box and "**MECH OF INJURY" as (O)ther**.

(C)cardiac: all acute cardiopulmonary emergencies including myocardial infarction or suspected heart attack.

(R)respiratory: choking incidents, asthma attacks, and other situations in which the patient's primary difficulty is failure to breathe adequately

(A)amputation: cases that involve potential re-implantation of a severed body part, cases involving complete or partial traumatic amputation of a body part.

(B)behavior/OD: intoxicated or psychologically disturbed patients, conditions related with alcohol or drug related syndromes including drug overdose, attempted suicide, and homicide victims; **does not include "5150" cases**.

(5)5150: patients transported to any mental health facility for 72-hour treatment and evaluation requested bylaw enforcement or other persons authorized to declare such treatment and evaluation

(U)burn: injury by fire, explosion, or chemical burn.

(D)domestic viol: calls involving child abuse or neglect, domestic partner abuse, elder abuse, or sexual assault. **Also specify "MECH. OF INJURY."**

(E)environment: diving casualties, radiation accidents, hypothermia, heat exhaustion, and other cases involving exposure to the elements. **Also specify "MECH. OF INJURY."**

(O)obstetric: problems relating to pregnancy, assistance with delivery, and postpartum emergencies.

(P)poisoning: emergencies resulting from ingestion, inhalation, or other exposure to toxic substances including intentional and accidental poisonings and hazardous materials' incidents; any call involving use of a poison control center.

(S)spinal inj: cranial and/or spinal trauma. **Specify "MECH. OF INJURY"**

(M)oth medical: other medical complaints such as diabetic complications, abdominal pain, or any medical problem involving a system other than the cardiac or respiratory system.

(N)transfer: any transfer of a patient from an acute care hospital to another facility.

BASE HOSP
Enter the base hospital code **(0-9)** only if BH was contacted. On the back of the F-1612 data form, find the name of the base hospital and the two-digit code next to the name. Mark the numbers corresponding to this code below the heading 'Base Hosp'.

NO HOSPITAL CONTACT-USE CODE "89"
Mark (Y)es if no BH contact attempted/needed, RCF or contact was with receiving hospital only.

Note:	**Base Hospital**	**No Contact**	**Interpreted As:**
	(blank)	Marked	no contact attempted/needed
	Marked	Marked	radio communications failure (follow RCF protocol)
	Marked	(blank)	successful base contact
	(blank)	Marked	Contact with receiving hosp only.

RECV HOSP
On the reverse side of the F-1612 data form, find the name of the receiving hospital and mark the two-digit code number **(0-9)** here. Use code **"77" for all subacute or chronic care facilities** (e.g., nursing homes). Use code "**99" for destinations other than acute care hospitals, subacute or chronic care facilities** (e.g., a residence). If the patient refuses transport or if another provider is transporting the patient, leave this item blank.

-TIMES-

CALL RECD
Time call is first received by EMS Provider Agency. Mark the numbers **(0-9)** that match the *"Received" time from the 01A Narrative form.* Use military time (a 24-hour clock). Valid times range from 0000 (midnight) to 2359 (11:59 p.m.). DO NOT USE 2400. **Note**: For walk-in patients, the time call received is when the patient walks in the door; depart is when the patient leaves; and all other times are blank.

ENROUTE
Time that the response unit begins physical motion; i.e. wheels begin to turn. Mark the numbers **(0-9)** that match the *"Enroute" time from the 01A Narrative form*.

ARRIVE (*Fieldname*: TIME ARRIVE)
Time the EMS unit stops physical motion at scene or staging area; i.e. wheels stop turning. Mark the numbers **(0-9)** that match the *"Arrive" time from the 01A Narrative form*.

DEPART (*Fieldname:* TIME DEPART)
Time when the response unit begins physical motion from scene, i.e. when the wheels begin to turn. . Mark the numbers **(0-9)** that match the *"Depart" time from the 01A Narrative form*. If you transport a patient, record DEPART as the time the ambulance leaves the scene enroute to the hospital or other destination. If the unit completing the run is not transporting the patient, record DEPART as the time when the unit is available for another call. If the patient refuses transport, record DEPART time as the time that you leave scene.

ARV DEST/END CALL (*Fieldname*: ARV DESTIN)
Time when patient arrives at destination or transfer point; i.e. wheels stop turning. Mark the numbers **(0-9)** that match the *"Arrive Dest" time from the 01A narrative form.* Leave blank if your unit is not transporting the patient. Note: Time call ended; i.e. AMA, the time a non-transport provider transferred care to a transport provider.

PT REFUSES CARE (*Fieldname*: REFUSE CARE)
Mark this area **(Y)** when a patient declines **all** prehospital treatment. In such situations, the patient must also sign the medical release section on the back of the first copy of the 01A Narrative form. If the patient refuses one or more specific types of care, document the type of care refused in the Narrative/Assessment section of the 01A narrative form.

RELEASE SIGNED
Mark this box **(Y)** when the patient refuses treatment and completes the "Medical Liability Release Form" on the *back of the first copy (white) of the 01A Narrative form.*

MEDICATIONS (*Fieldname*: MEDICATION)
Mark as many boxes **(A, H, B, J, P, K, D, 1, 2, E, Q, F, G, L, R, S, M, N, 3, W, C, 4, V, U)** as apply. Mark ONLY the box(es) given by the unit recording this run. The medications are listed alphabetically; **(A)act. charcoal, (H)adenosine, (B)albuterol, (J)aspirin, (P)atropine, (K)bretylium, (D)dextrose, (1)diphenhydram, (2)dopamine, (E)epineph-IV, (Q)epineph-SQ, (F)furosemide, (G)glucagon, (L)lidocaine, (R)magnesium, (S)midazolam, (M)morphine, (N)naloxone, (3)nitroglycerine, (W)phenylephrine, (C)procainade, (4)sodium bicarb, (V)verapamil, (U)other med, for medication(s) administered but not listed.** For Interfacility Transfers, mark boxes for medication that are being monitored by the EMT-P during the transfer.

CARE RENDERED (*Fieldnames*: CARE1/CARE2)

For service or treatment provided, mark as many boxes as apply in the BLS (left column) **(F, A, M, B, P, D, E, C, H, K, N, O, X, G, I, S, T, L, W, U)** or ALS (right column) **(B, D, E, T, F, G, 1, 2, 3, 4, O, P, N, C, Y, H, V, U)**. Mark each treatment or procedure only once, though it may have been done for this patient several times. Mark only those services provided by your unit. Document services provided by non-EMS individuals or other agencies in the "Narrative/Assessment" section of the 01A form. Other agencies must document services provided by their agency on their O1A form and F-1612 data form.

BLS SERVICES(*Fieldname*: CARE 1):(Care Rendered [Left Column])

(F)AED	when used on patient
(A)bag-valve mask	on resuscitation
(M)burn care	on burns
(B)axial spinal stabilization	on patient
(P)CPR/resuscitation	when preformed on patient
(D)decontamination	usually associated with exposure to hazardous materials
(E)extrication	from a vehicle or hazardous situation; if time > than 10 minutes, record the approx. time in the Narrative/Assessment section of the 01A form
(C)hard collar	to immobilize the neck
(H)hot/cold packs	on patient

(K)KED	on patient
(N)NP/OP airway	on attempts to establish a nasopharyngeal or oral pharyngeal airway
(O)OB assist	on assistance with obstetrical delivery
(X)oxygen	on administration to patient
(G)sand bags	used for patient
(I)snake bite kit	on patient
(S)splint, simple	on patient
(T)splint, traction	on patient
(L)suction	on patient
(W)wound dressing	on patient
(U)BLS Other	for a BLS procedure other than those listed

ALS SERVICES (*Fieldname*: CARE 2):(Care Rendered [Right Column])

(B)blood drawn	on patient
(D)dexstick	on patient
(E)EKG monitor	on patient (**also mark the "1 ST EKG" section**)
(T)EKG strip	on patient
(F)12 lead EKG	on patient
(G)McGill forceps	on an attempted or performed foreign body removal
(1)Meds given IV	route given to pt
(2)Meds given IO	route given to pt
(3)Meds given ET	route given to pt
(4)Meds given PO	route given to pt
(O)monitor chest tubes	on an attempted, inserted a chest tube, or monitored
(P)needle thoracostomy	on an attempted or performed needle thoracostomy
(N)NG insertion	on an attempted, inserted or monitored NG tube
(C)Percutaneous Needle Cric	if attempted, or inserted
(Y)Approved Device	Quick Trach Device
(H)TCP	if attempted or placed
(V)Valsalva maneuver	on patient
(U)ALS Other	for an ALS procedure other than those listed, for transfer patients mark this box if EMT-P is monitoring IV medication during the transfer.

SYS BP
Mark the box **(4-0)** next to the category in which the patient's initial systolic blood pressure reading falls. If no systolic BP is present, mark the space for "0." Blood pressures are usually obtainable on pediatric patients with a pediatric BP cuff. If you obtain no BP, leave this area blank. **LIST ONLY VITAL SIGNS TAKEN BY YOUR AGENCY**.

RESP RATE
Using the **first** observation of the patient's respiratory rate, mark the box **(4-0)** next to the category in which the patient's rate (in number of respiration's per minute) occurs. For example, if the patient's respiration rate is 20, mark the top space, numbered 4.

EFFORT
Referring to **initial** respiratory effort (chest wall movement), mark the box **(1 or 0)** next to the category that better describes the situation for this patient~normal, or shallow/refractive/none.

CAP REFILL
Mark the box **(2, 1, 0)** that best describes the patient's capillary refill upon **initial assessment**.

BEST MOTOR (*Fieldname*: MOTOR)
Mark the box **(6-1)** next to the patient's **initial** best motor response.

BEST VERBAL (*Fieldname*: VERBAL)
Mark the box **(5-1)** next to the category that describes this patient's **initial** best verbal response.

EYE OPEN
Note the patient's **initial** ability to open his/her eye(s). Mark the box **(4-1)** next to the category**.**

(R)cardiovert (D)defib (*Fieldname*: D-FIB)
Mark **(R)CARDIOVERT (D)DEFIB** if performed by the unit recording this run.

1ST EKG
Mark **one** box **(N, B, T, V, C, D, I, L, E, A, Y, O)** for the code of the **first rhythm detected** on EKG by unit recording this run, *as recorded on the 01A Narrative*.

(N)SR: Normal sinus rhythm
(B)SB: Sinus bradycardia; heart rate <60 beats per minute
(T)ST: Sinus tachycardia; heart rate >100 per minute
(V)Vfib: Ventricular fibrillation
(C)VT: Ventricular tachycardia (V tach)
(D)SVT: Super ventricular tachycardia
(I)Afib: Atrial fibrillation
(L)AFL: Atrial flutter
(E)AT: Atrial tachycardia
(A)AVB: Atrioventricular block (AV block) or heart block
(Y)ASY: Asystole
(O)Oth Unidentifiable rhythm

ATTEMPTS PLACED

IV (*Fieldnames*: IV ATTEMPT/IV2 ATTEMPT)
Mark **(1, 2, or 3+)** for three or more attempts to place IV needle. If successful, mark **(Y)**. For bilateral (or 3 or more) IV's, the number of IV attempts means the maximum number of attempts made to insert any of the needles. If both were placed successfully on the first try, mark "1." If one IV took two tries before placement, mark "2," etc.

IO (*Fieldnames*: IO ATTEMPT/IO2 ATTEMPT)
Mark **(1, 2, or 3+)** for three or more attempts to place IO needle. If successful, mark **(Y)**. For bilateral (or 3 or more) IO's, the number of IO attempts means the maximum number of attempts made to insert any of the needles. If both were placed successfully on the first try, mark "1." If one IO took two tries before placement, mark "2," etc.

ET (*Fieldnames*: ET1 ATTEMPT/ET1A ATTEMPT)
Mark **(1, 2, or 3+)** for three or more attempts to place tube. If successful mark **(Y).**

ET-NASAL (*Fieldname*: ET2 ATTEMPT)
Indicate placement of ET: **(N)**nasal or **(O)**oral.

PT CONDITION
Mark the patient's overall response to treatment. BLANK IS INVALID. This category refers to the patient's response to all treatment rather than to a specific drug or procedure. Mark **(C)changed** or **(N)no change** during transport.

IV/IO
Mark box for saline or **(S)** OR **(L)**

SPECIAL STUDY
Use this area whenever a special study is conducted. Mark all boxes **(M, S, or O)** that apply.
(M)Medications
(S)Skills
(O)other.

OUTCOME
Mark the box **(C, D, R, G, A, O)** next to the category that best describes this call. *BLANK IS INVALID*.

(C)canceled enroute: Call canceled by agency dispatcher prior to arrival at a scene and if the run is canceled on scene before you make pt contact.
(D)dry run-no pt No patient was found at the scene, the unit was unable to locate the scene or the patient, or the patient refuses to communicate so you cannot obtain any patient information.
(R)transport refused: The patient accepted care by an EMS field provider but refused to be transported by any EMS provider, and for walk-in patients.
(G)transport-ground: Patient received prehospital care, was transported by this or another ground ambulance, or if patient care was transferred to another unit.
(A)transport-air: Patient received prehospital care, was transported by helicopter or fixed-wing aircraft, and for patient to loading zone and patient care to EMS air.
(O)obviously dead: Patient showed obvious signs of death, per protocol.

WHY SELECTED
Mark the category **(T, P, D, C, E, R, O)** that most closely matches the reason for selection of the receiving hospital. If the base hospital indicates a reason, mark the hospital's determination of "why selected."

(T)major trauma: a trauma center is required.
(P)patient request: patient or patient's physician requests transport to a specific facility
(D)diversion: the original receiving hospital selected was on diversion
(C)closest: the hospital is closest to the scene.
(E)peds trauma: pediatric trauma center is required.
(R)reroute: the receiving hospital destination changed while the unit was enroute (e.g., a change in patient condition required selection of a different facility). Does not include change in a destination based upon hospital status
(O)other: a reason other than those listed was used in selecting the receiving hospital.

ICEMA# (*Fieldname*: ICEMA#2)
Mark six boxes **(0-9**) to indicate the ICEMA number printed on the upper left corner of the 01A Narrative form for this patient. An ICEMA number is required here, **except for dry runs or canceled calls**.

ATTENDANT #1 CERT NO (*Fieldnames*: CERT#1A/CERT#1B)
Mark the first box **(E, L, P, or M)** to indicate the level of accreditation/certification for primary patient caregiver reporting on this run. P for paramedic, E for emergency medical technician, or M for mobile intensive care nurse (on interfacility transfers). Mark the ICEMA accreditation/certification numbers **(0-9)** in the remaining boxes**.** If your ICEMA number is less than four digits, use zeroes before the number to fill the four boxes. **Provisional paramedics or MICNs who are third members of the ambulance crew sign the 01A narrative form, but enter no data on the F-1612 data form.**

ATTENDANT #2 CERT NO (*Fieldnames*: CERT#2A/CERT#2B)
Mark the first box **(E, L, P, or M)** to indicate the type of accreditation/certification for the secondary patient caregiver reporting on this run. Mark the ICEMA accreditation/certification number **(0-9)** in the remaining boxes. If your number is less than five digits, use leading zeroes before the number as needed to fill the boxes.

THIS FORM BY PROVIDER/UNIT (*Fieldnames*: PROVIDER B/UNIT B)
Obtain your 3-digit provider code from the list on the back of the F-1612 data form. Mark the box with these three digits **(0-9)** below "Provider." For all agencies, mark three numbers that represent the unit number of the vehicles in which you are riding on this call. Use leading zeroes.

TRANSP CODE2 (THIS FORM BY)
Enter the type of unit for the agency reporting this run.

(MA)Medic Ambulance
(MS)Medic Squad
(ME)Medic Engine
(AM)Ambulance
(SQ)Squad
(E)Engine

REVERSE SIDE OF F-1612 DATA FORM

PUBLIC PROVIDERS
Fire department EMS providers, use provider code followed by the unit type (MA, ME, MS, AM, SQ, E) and three-digit unit number as assigned by Fire Chiefs. **Use code 888 for other Public Providers outside the ICEMA region**.

PRIVATE PROVIDERS
A three-digit code is assigned to each private ALS or BLS provider agencies within the region. Provider codes are used in the area for "Other Transport Provider" on the F-1612 data form (upper right corners) as well as for the "This Form By" provider code in the lower right corner. Codes are organized alphabetically by county. The provider code is followed by a three-digit unit number assigned by ICEMA, e.g., 001. **Use code 999 for other Private Providers outside the ICEMA region.**

HOSPITAL CODES
Two-digit code numbers have been assigned to each hospital within the ICEMA region. These codes are used in the "Base Hospital" and "Receiving Hospital" areas of the F-1612 data form. They are listed alphabetically by hospital name. **Use code 88 for all hospitals outside the ICEMA region**.

INCIDENT CITY CODES
These three-digit code numbers are to be used to complete the "City" area in the upper right portion of the F-1612 data form. To find a code, first locate the section of the form for the appropriate county within the region (Inyo, Mono, or San Bernardino). For San Bernardino County, check the subheadings for the appropriate geographical area (e.g., West Valley or High Desert). Cities and communities are listed alphabetically within the county or area. If the city or community where the incident occurred is not listed, use the code for the city or community nearest to the incident location; if none, use the code for "Inyo Co. Other," "Mono Co. Other," or "San Bernardino Co. Other," as appropriate.

INSTRUCTIONS FOR SUBMITTING DATA VIA EMAIL

The data fields were taken from the State EMS regulations (Title 22) for an EMT-P patient care record and items recommended by the State EMS Data Study Task Force, which include items suitable for computerization. The data fields are required for evaluation of the EMS State grant contract and include key fields necessary to provide required reports, edit, and cross-referencing with dispatch and E.D. logs. The data should be submitted within thirty days following the Run Date and must include all the provider agency runs where they made patient contact, canceled calls and dry runs. **The provider agency should edit all their own records for any missing data and invalid codes before submitting it to ICEMA** at Memanuel@dph.sbcounty.gov. The data file format is a comma delimited ASCII File with a .txt file extension. Dates are in the Year-Month-Day format; e.g., 20040601 is June 01, 2004. The data fields MUST be in the **EXACT** order as listed below and in the correct starting position in the data set.

FIELD NAME	*STARTING POSITION IN DATA FILE*	*DEFINITION*	*LENGTH*	*VALID CHARACTERS*
GENDER (SEX)	1	Patient gender	1	M,F,U
INS0	2	End of field	1	Comma
AGE	3	Patient age, in whole years *Blank if unknown*	2	Numerics: 0-9
INS1	5	End of field	1	Comma
ZIP (Zip Code)	6	First 5 digits of patients mailing address zip code	5	Numerics: 0-9
INS2	11	End of field	1	Comma
PTS (#Pts)	12	Number of patients at this incident scene *Or blank*	1	Numerics: 0-9
INS3	13	End of field	1	Comma
INCIDENT#	14	Provider agency incident/dispatch #	8	Numerics: 0-9
INS4	22	First 2 Numbers of the Year 2000	3	,20
RUN-YEAR1	25	Third Number of Year in 2000	1	9,0,1
RUN-YEAR2	26	Fourth Number of Year in 2000	1	Numerics: 0-9
RUN-MONTH	27	Month	2	Numerics: 0-9
RUN-DAY	29	Day	2	Numerics: 0-9
INS5	31	End of field	1	Comma
CITY	32	Incident location *e.g., use 888 For County Jail*	3	Numerics: 0-9
INS6	35	End of field	1	Comma
RUN TO CODE (Run Code-To)	36	Code TO scene	1	1, 2, 3
INS7	37	End of field	1	Comma
RUN FR CODE (Run Code-From)	38	Code FROM scene	1	1,2,3
INS8	39	End of field	1	Comma
PROVIDER A (Other Transport-Provider)	40	Provider code of another provider on scene. *See back of Scantron form for valid codes. Enter this information only if a second unit is on scene and makes patient contact*	3	Numerics: 0-9
INS9	43	End of field	1	Comma
UNIT A (Other Transport-Unit)	44	Unit number of another provider on scene. *See back of Scantron form for valid codes. Enter this information only if a second unit is on scene and makes patient contact*	3	Numerics: 0-9
INS10	47	End of field	1	Comma
ICEMA#1 (Other ICEMA #)	48	Enter another agency's 01A form number whenever another ALS provider is on scene and	6	Numerics: 0-9

FIELD NAME	*STARTING POSITION IN DATA FILE*	*DEFINITION*	*LENGTH*	*VALID CHARACTERS*
		makes contact with the same patient. *This field cross-references multiple forms completed on the same patient/same incident*		
INS11	54	End of field	1	Comma
PRIOR CARE	55	Enter the Identifying care giver, if any, prior to arrival of unit	1	N,M,B,C,O,L,A
INS12	56	End of field	1	Comma
INJURY MECH (Mech of Injury-Trauma Only)	57	Enter the one category that best describes the mechanism of injury precipitating this call	1	M,C,G,S,A,D,F,B,L,T,P,O,U
INS13	58	End of field	1	Comma
SEATBELT (Auto/Truck MVA)	59	Enter if patient was wearing a seatbelt or other safety restraint. **MUST be entered for all MVA's.**	1	Y,N,U
INS14	60	End of field	1	Comma
HELMET (Motorcycle)	61	Enter if patient was wearing a protective helmet. **MUST be entered for all MVA's involving motorcycles or bicycles.**	1	Y,N,U
INS15	62	End of field	1	Comma
CATEGORY	63	Enter the ONE category that best fits this patient	1	T,C,R,A,B,5,U,D,E,O,P,S,M,N
INS16	64	End of field	1	Comma
BASE HOSP	65	Enter the Base Hospital Code only if BH was contacted	2	Numerics: 0-9
INS17	67	End of field	1	Comma
NO CONTACT	68	Enter if no BH contact attempted/needed, RCF or contact was with receiving hospital only	1	Y
INS18	69	End of field	1	Comma
RECV HOSP	70	Enter the valid code of RH, leave blank if patient refuses transport or if another provider is transporting the patient	2	Numerics: 0-9
INS19	72	End of field	1	Comma
CALL RCD	73	Enter the time call received by provider agency dispatch, in military time *4:16 p.m.=1616*	4	Numerics: 0-9
INS20	77	End of field	1	Comma
EN ROUTE	78	Enter the time unit *leaves* to scene	4	Numerics: 0-9
INS21	82	End of field	1	Comma
TIME ARRIVE (Times-Arrive)	83	Enter the time unit *arrives* at scene and wheels stop	4	Numerics: 0-9
INS22	87	End of field	1	Comma
TIME DEPART (Times-Depart)	88	Enter the time unit *departed* scene to hospital	4	Numerics: 0-9
INS23	92	End of field	1	Comma
ARV DESTIN (Arv Dest)	93	Enter the time unit *arrives* at hospital	4	Numerics: 0-9
INS24	97	End of field	1	Comma
REFUSE CARE	98	Enter when patient declines ALL prehospital treatment, if the patient refuses one or more specific types of care, document on the O1A form	1	Y
INS25	99	End of field	1	Comma
MEDICATION	100	Enter only medications given by the unit recording this run	24	A,H,B,J,P,K,D,1,2,E,Q,F,G,L,R,S, M,N,3,W,C,4,V,U
INS26	124	End of field	1	Comma

FIELD NAME	*STARTING POSITION IN DATA FILE*	*DEFINITION*	*LENGTH*	*VALID CHARACTERS*
CARE 1 (Care Rendered [Left Column])	125	Enter only BLS services given by the unit recording this run	20	F,A,M,B,P,D,E,C,H,K,N,O,X,G,I, S,T,L,W,U
INS27	145	End of field	1	Comma
IV/IO (IV-Saline) (added to field name)	146	Enter type of IV solution given by the unit recording this run	1	S,L
INS28	147	End of field	1	Comma
CARE 2 (Care Rendered [Right Column])	148	Enter only ALS services given by the unit recording this run	18	B,D,E,T,F,G,1,2,3,4,O,P,N,C,Y,H, V,U
INS29	166	End of field	1	Comma
SYS BP	167	Enter the category in which the patient's initial systolic blood pressure reading falls, if not present, enter 0, leave blank if no BP is obtained. Enter ONLY vital signs taken by the unit recording this run	1	Numerics: 4-0
INS30	168	End of field	1	Comma
RESP RATE	169	Enter first observation of patient's rate	1	Numerics: 4-0
INS31	170	End of field	1	Comma
EFFORT	171	Enter initial respiratory effort of patient	1	1,0
INS32	172	End of field	1	Comma
CAP REFILL	173	Enter initial cap refill of patient	1	2,1,0
INS33	174	End of field	1	Comma
MOTOR (Best Motor)	175	Enter initial motor response of patient	1	Numerics: 6-1
INS34	176	End of field	1	Comma
VERBAL (Best Verbal)	177	Enter initial verbal response of patient	1	Numerics: 5-1
INS35	178	End of field	1	Comma
EYE OPEN	179	Enter initial eye opening response of patient	1	Numerics: 4-1
INS36	180	End of field	1	Comma
D-FIB (Cardiovert/dfib)	181	Enter if performed by the unit recording this run	1	R,D
INS37	182	End of field	1	Comma
1ST EKG	183	Enter code for first rhythm detected on EKG by unit recording this run	1	N,B,T,V,C,D,I,L,E,A,Y,O
INS38	184	End of field	1	Comma
IV ATTEMPT (Attempts Placed-IV)	185	Enter the number of IV attempts	1	1,2,3
INS39	186	End of field	1	Comma
IV2 ATTEMPT (Attempts Placed-IV-Y)	187	Enter ONLY if IV placed successfully	1	Y
INS40	188	End of field	1	Comma
ET1 ATTEMPT (Attempts Placed-ET)	189	Enter the number of ET attempts	1	1,2,3
INS41	190	End of field	1	Comma
ET1A ATTEMPT (Attempts Placed-Y)	191	Enter ONLY if ET placed successfully	1	Y
INS42	192	End of field	1	Comma
ET2 ATTEMPT (Attempts Placed-ET-Nasal)	193	Enter placement of ET	1	N,O
INS43	194	End of field	1	Comma

FIELD NAME	*STARTING POSITION IN DATA FILE*	*DEFINITION*	*LENGTH*	*VALID CHARACTERS*
PT CONDITION	195	Enter patient's overall response to treatment. **BLANK IS INVALID**	1	C,N
INS44	196	End of field	1	Comma
OUTCOME	197	Enter category that best describes call. **BLANK IS INVALID**	1	C,D,R,G,A,O
INS45	198	End of field	1	Comma
WHY SELECTED	199	Enter category that matches reason for selecting RH	1	T,P,D,C,E,R,O
INS46	200	End of field	1	Comma
ICEMA#2 (ICEMA#)	201	Enter ICEMA 01A report form number by unit recording this run	6	Numerics: 0-9
INS47	207	End of field	1	Comma
CERT#1A (Attendant #1 Cert No.-Alphas)	208	Enter type of accreditation/certification for primary patient caregiver reporting on this run.	1	E,L,P,M
CERT#1B (Attendant #1 Cert No.-Numerics)	209	Enter ICEMA four-digit accreditation/certification number for primary patient caregiver reporting on this run.	4	Numerics: 0-9
INS48	213	End of field	1	Comma
CERT#2A (Attendant #2 Cert No.-Alpha)	214	Enter type of accreditation/certification for secondary patient caregiver reporting on this run.	1	E,L,P,M
CERT#2B (Attendant #2 Cert No.-Numerics)	215	Enter ICEMA four or five-digit accreditation/certification number for secondary patient caregiver reporting on this run.	5	Numerics: 0-9
INS49	220	End of field	1	Comma
PROVIDER B (This Form by-Provider)	221	Enter the valid provider code for the agency reporting this run	3	Numerics: 0-9
INS50	224	End of field	1	Comma
UNIT B (This Form by-Unit)	225	Enter the valid unit code for the agency reporting this run	3	Numerics: 0-9
INS51	228	End of field	1	Comma
SCANTRON#/LITHOCODE	229	Binary Summation Leave 6 spaces blank	6	Leave no marks in this field
INS52	235	End of field	1	Comma
TRANSP CODE1 (OTHER TRANSPORT-Top right of Scantron form)	236	Enter the type of unit for another provider on scene. *Enter this information only if a second unit is on scene and makes patient contact*	2	MA,MS,ME,AM,SQ,E
INS53	238	End of field	1	Comma
TRANSP CODE2	239	Enter the type of unit for the agency reporting this run	2	MA,MS,ME,AM,SQ,E
INS54	241	End of field	1	Comma
SP STUDY (Special Study)	242	Enter category ONLY if reporting data for a special study	3	M,S,O
INS55	245	End of field	1	Comma
RELEASE SIGNED	246	Enter if AMA was signed on 01A Form	1	Y
INS56	247	End of field	1	Comma
IO ATTEMPT (Attempts Placed-IO)	248	Enter the number of IO attempts	1	1,2,3
INS57	249	End of field	1	Comma
IO2 ATTEMPT (Attempts Placed-IO-Y)	250	Enter ONLY if IV placed successfully	1	Y

PROVIDER 078

Reference: 14015

ICEMA # 514802

Prim. Inc. # _____ Other Provider _____

Date _____ Unit _____

Location of Call _____ (Do not write "Same")

City _____ Zone _____

CARE PRIOR TO ARRIVAL ☐ None ☐ CPR ☐ ALS ☐ Other BLS	☐ CITZ ☐ Medical ☐ FD/BLS ☐ None ☐ Law Enforce ☐ FD/ALS ☐ ALS Ambulance

NAME _____

ADDRESS _____

City _____ State _____ Zip _____

Phone _____ Social Security No. _____

Age _____ DOB ___/___/___ ☐ M ☐ F Approx. Weight _____ kg Approx. Height _____ Pt. ____ of ____

CHIEF COMPLAINT _____

HELMET Y / N
SEAT BELT Y / N
LOC Y / N
AIR BAG Y / N

MECH. OF INJ. _____

MED. HISTORY: ☐ Asthma ☐ Cancer ☐ CVA ☐ Cardiac ☐ CHF ☐ COPD ☐ Diabetes ☐ HTN ☐ Psych ☐ Seiz

MEDICATION: _____

ALLERGIES: ☐ NKA _____

	TIME	CODE	ODOMETER	
RECEIVED		1 2 3		
ENROUTE				
ARRIVE				
PT. CONTACT				
DEPART		1 2 3		
ARRIV. DEST.				
AVAILABLE				

FAC. CONTACTED _____ CONTACT TIME _____

☐ BH ☐ VHF ☐ UHF ☐ Phone ☐ Cell ☐ 800 MHZ ☐ None

RECEIVING HOSP. _____

☐ Pt Request ☐ Diversion ☐ Trauma ☐ RCF
☐ Peds Trauma ☐ Reroute ☐ Closest ☐ Other

TIME	BLOOD PRESSURE	PULSE Rate	PULSE Description	RESPIRATION Rate	RESPIRATION Lung Sounds	PULSE OX

SECONDARY SURVEY

	WNL	N/A	ABN	COMMENTS
NEURO	☐	☐	☐	
HEAD	☐	☐	☐	
NECK	☐	☐	☐	NO JVD
CHEST	☐	☐	☐	NEG BARREL HOOP
ABD	☐	☐	☐	SOFT/SUPPLE
BACK-SPINE	☐	☐	☐	FULL SPINAL IMMOBILZATION
PELVIS	☐	☐	☐	NEG NO INSTABILITY NOTED
EXTREM	☐	☐	☐	NO DISTAL EDEMA FULL R.O.M.

NARCOTIC GIVEN

Midazolam _____ mg
Morphine _____ mg

NARCOTIC WASTED

Midazolam _____ mg
Morphine _____ mg
Date _____ Time _____
Location _____
Nurse _____
Medic _____

SKIN COLOR: [A] [B] Normal, Pale/Ashen, Cyanotic, Flushed

MOISTURE: [A] [B] Normal, Dry, Moist, Profuse

SKIN TEMP.: [A] [B] Hot, Warm, Cool, Cold

PUPILS Rt.: [A] [B] Normal, Constricted, Dilated

Lt.: [A] [B]

PUPILS Rt.: [A] [B] Non-reactive, Sluggish

Lt.: [A] [B]

Time A _____ Time B _____

PT PHYSICIAN _____ Temp _____ Rte. _____

Blood Glucose a D50 _____ p D50 _____ mg/dL

RESPIRATORY EFF.: [A] [B] Normal, Shallow/Retract/None

CAPILLARY REFILL: [A] [B] Immediate, Delayed, None

EYE OPENING: [4] [4] Spontaneous, [3] [3] To voice, [2] [2] To pain, [1] [1] None

VERBAL RESPONSE: [5] [5] Oriented, [4] [4] Confused, [3] [3] Inappropriate, [2] [2] Incomprehensible, [1] [1] None

MOTOR RESPONSE: [6] [6] Obedient, [5] [5] Purposeful, [4] [4] Withdrawal, [3] [3] Flexion, [2] [2] Extension, [1] [1] None

End-Tidal Co2 Detected

After ET Placement (Use Narrative) ☐ Yes ☐ No

Before and After Transfer To Amb. Gurney (Use Narrative) ☐ Yes ☐ No

PULSE:

	FEMORAL	RADIAL	CAROTID
PRESENT	[A] [B]	[A] [B]	[A] [B]
ABSENT	[A] [B]	[A] [B]	[A] [B]

GCS _____

TIME	RHYTHM	DEFIB	RHYTHM

TIME ADM.	CARE RENDERED	RT/SIZE	DOSE	RESPONSE TX

P	Q	R	S	T

NARRATIVE/ASSESSMENT: _____

Name (Print) _____ Cert/Acc # _____ ☐ Patient attendent ☐ Radio attendent ☐ Completed form ☐ Other	Name (Print) _____ Cert/Acc # _____ ☐ Patient attendent ☐ Radio attendent ☐ Completed form ☐ Other	Name (Print) _____ Cert/Acc # _____ ☐ Patient attendent ☐ Radio attendent ☐ Completed form ☐ Other

☐ CHECK BOX IF FORM NOT COMPLETED ON SCENE

PT RECEIVED BY

MULTIPLE PATIENT TRIAGE FORM

Patient Name _____ Unit # _____

Pt # | AGE ____ ORDERS _____

[ ] M [ ] F _____

Chief Complaint/Mech. of Injury _____

PULSE:	Present	Absent	RESP RATE	EFFORT	CAP REFILL
FEMORAL	[ ]	[ ]	[ ] 10-24	[ ] normal	[ ] normal
CAROTID	[ ]	[ ]	[ ] 25-35	[ ] shallow	[ ] delayed
RADIAL	[ ]	[ ]	[ ] > 35	[ ] retract.	[ ] none
			[ ] < 10	[ ] or none	
			[ ] 0		

EYE OPEN
[4] spontan
[3] to voice
[2] to pain
[1] none

BEST VERBAL
[5] oriented
[4] confused
[3] inappropriate
[2] incomprehens.
[1] none

BEST MOTOR
[6] obedient
[5] purposeful
[4] withdrawal
[3] flexion
[2] extension
[1] none

GCS ____

TIME	BP	PULSE	RESP

Patient Name _____ Unit # _____

Pt # | AGE ____ ORDERS _____

[ ] M [ ] F _____

Chief Complaint/Mech. of Injury _____

PULSE:	Present	Absent	RESP RATE	EFFORT	CAP REFILL
FEMORAL	[ ]	[ ]	[ ] 10-24	[ ] normal	[ ] normal
CAROTID	[ ]	[ ]	[ ] 25-35	[ ] shallow	[ ] delayed
RADIAL	[ ]	[ ]	[ ] > 35	[ ] retract.	[ ] none
			[ ] < 10	[ ] or none	
			[ ] 0		

EYE OPEN
[4] spontan
[3] to voice
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BEST VERBAL
[5] oriented
[4] confused
[3] inappropriate
[2] incomprehens.
[1] none

BEST MOTOR
[6] obedient
[5] purposeful
[4] withdrawal
[3] flexion
[2] extension
[1] none

GCS ____

TIME	BP	PULSE	RESP

Patient Name _____ Unit # _____

Pt # | AGE ____ ORDERS _____

[ ] M [ ] F _____

Chief Complaint/Mech. of Injury _____

PULSE:	Present	Absent	RESP RATE	EFFORT	CAP REFILL
FEMORAL	[ ]	[ ]	[ ] 10-24	[ ] normal	[ ] normal
CAROTID	[ ]	[ ]	[ ] 25-35	[ ] shallow	[ ] delayed
RADIAL	[ ]	[ ]	[ ] > 35	[ ] retract.	[ ] none
			[ ] < 10	[ ] or none	
			[ ] 0		

EYE OPEN
[4] spontan
[3] to voice
[2] to pain
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BEST VERBAL
[5] oriented
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[1] none

BEST MOTOR
[6] obedient
[5] purposeful
[4] withdrawal
[3] flexion
[2] extension
[1] none

GCS ____

TIME	BP	PULSE	RESP

Patient Name _____ Unit # _____

Pt # | AGE ____ ORDERS _____

[ ] M [ ] F _____

Chief Complaint/Mech. of Injury _____

PULSE:	Present	Absent	RESP RATE	EFFORT	CAP REFILL
FEMORAL	[ ]	[ ]	[ ] 10-24	[ ] normal	[ ] normal
CAROTID	[ ]	[ ]	[ ] 25-35	[ ] shallow	[ ] delayed
RADIAL	[ ]	[ ]	[ ] > 35	[ ] retract.	[ ] none
			[ ] < 10	[ ] or none	
			[ ] 0		

EYE OPEN
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[3] inappropriate
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[1] none

BEST MOTOR
[6] obedient
[5] purposeful
[4] withdrawal
[3] flexion
[2] extension
[1] none

GCS ____

TIME	BP	PULSE	RESP

PATIENT TRANSPORTATION RECORD / MCI WORK SHEET

TRANSPORT AGENCY / UNIT #		DESTINATION	PT#/TAG#	AGE	SEX	PRIORITY (I IMMED D DELAY M MINOR)	CHIEF COMPLAINT	ETA	OFF SCENE TIME
AMB. CO.	0	HOSPITAL	..000	0 0	M	(I) (D) (M)	FX LEG	0	0 0 0 0
						(I) (D) (M)			
						(I) (D) (M)			
						(I) (D) (M)			
						(I) (D) (M)			
						(I) (D) (M)			
						(I) (D) (M)			
						(I) (D) (M)			
						(I) (D) (M)			
						(I) (D) (M)			

THROMBOLYTIC ASSESSMENT

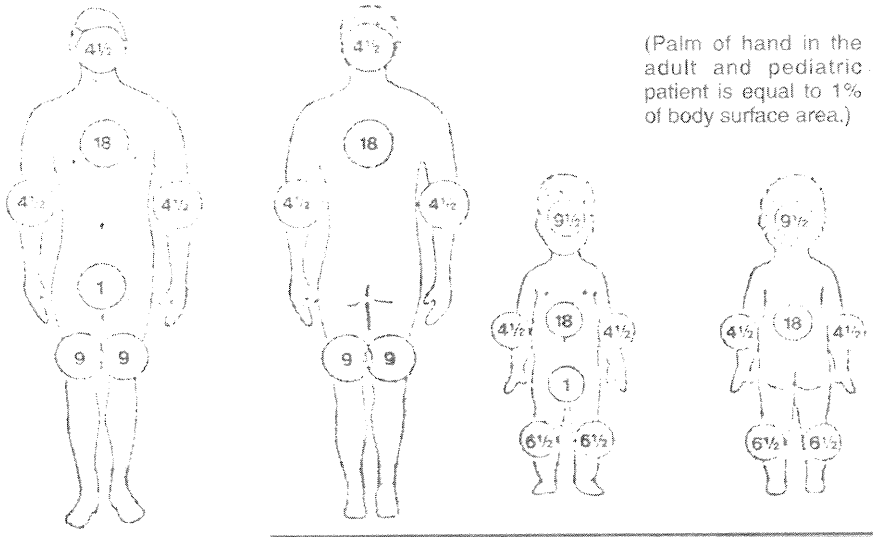
	Yes	No
Onset greater than 4 hours	☐	☐
Hx of recent bleeding episode	☐	☐
Documentation of hemoptysis, GI or ENT hemorrhage	☐	☐
Hx of intracranial hemorrhage	☐	☐
Hx of recent stroke - within 6 months (nonhemorrhage)	☐	☐
Age greater than 80	☐	☐
Sustained B/P greater than 180 systolic	☐	☐

	Yes	No
Hx of previous thrombolytics	☐	☐
Recent Streptococcal infection	☐	☐
Severe diabetic retinopathy	☐	☐
Hx of major surgery - within 2 weeks	☐	☐
Hx of recent trauma, prolonged CPR, or coma	☐	☐
I.J. or subclavian venipuncture within 2 weeks	☐	☐

BASE HOSPITAL/RECEIVING FACILITY

ARMC = Arrowhead Regional Medical Center (08)
BCH = Barstow Community Hospital (10)
BMH = Barton Memorial Hospital (15)
BVCH = Bear Valley Community Hospital (11)
MH = Mammoth Hospital (08)
CCVMC = Columbia Chino Valley Medical Center (25)
CRMC = Colorado River Medical Center (27)
CVMC = Carson Valley Medical Center (14)
CTH = Carson Tahoe - Nevada (09)
DSH = Desert Springs - Nevada (01)
DVH = Desert Valley Hospital (21)
HDMC = Hi-Desert Medical Center (31)
KPMC-F = Kaiser Permanente - Fontana (59)
LLCH = Loma Linda Community Hospital (68)
LLU = Loma Linda University Med. Center (69)
NIH = Northern Inyo Hospital (79)
MCMG = Mono County Medical Group (74)
MTCH = Mountains Community Hospital (76)
RDCH = Redlands Community Hospital (91)
SACH = San Antonio Community Hospital (96)
SBC = Community Hospital of San Bernardino (98)
SIH = Southern Inyo Hospital (05)
STBMC = St. Bernardine Medical Center (06)
SMDV = St. Mary's Regional Medical Center (07)
STM = St. Mary's - Nevada (12)
SH = Humana Sunrise Hospital - Las Vegas (02)
TNPM = Twentynine Palms Marine Hospital (29)
UNLV = University Med. Center - Nevada (03)
USF = US Family Care (41)
VMH = Valley Memorial Hospital - Nevada (04)
VAH = Veterans Administration Hospital (95)
VVCH = Victor Valley Community Hospital (18)
WMC = Washoe Medical Center - Reno (13)
WANFI = Weed Army Hospital Fort Irwin (19)

RULES OF NINES



(Palm of hand in the adult and pediatric patient is equal to 1% of body surface area.)

Sign	0	1	2	1 min.	5 min.
Heart Rate	Absent	Below 100	Over 100		
Respiration (effort)	Absent	Slow and irregular	Normal; crying		
Muscle Tone	Limp	Some flexion-extremities	Active; good motion		
Irritability	No response	Crying; some motion	Crying; vigorous		
Skin Color	Bluish or Paleness	Pink or typical newborn color, hands and feet are blue	Pink or typical newborn color, entire body		
			TOTAL APGAR SCORE		

STANDARD ABBREVIATIONS

a̅	Before
AMA	Against Medical Advice
B-Board	Back board
BH	Base Hospital
B.V.M.	Bag/valve/mask
Bilat.	Bilateral
BP, B/P	Blood pressure
C-collar	Cervical collar
C-spine	Cervical spine
C/o, c.o.	Complains of
Citz	Citizen
c̅	With
CHF	Congestive heart failure
cc	Cubic centimeters
CVA	Cerebral Vascular Accident
COPD	Chronic Obstructive Pulmonary Dx
Diff. breath	Difficulty breathing
Defib.	Defibrillation
DNO	Did not obtain/Did not order
Dz	Disease
Dx	Diagnosis
EBL	Estimated blood loss
ETOH	Alcohol Intoxication
Fx	Fracture
g.	Gauge (i.e. 18 g. angio)
Gm	Grams
GSW	Gunshot wound
HBD	Has been drinking
HTN	Hypertension
Hx	History
I.V.P.	Intravenous push
I.V.P.B.	Intravenous piggy back
IM	Intramuscular
IV	Intravenously
Irr	Irregular
J.	Joules
JVD	Jugular venous distention
kg	Kilogram
LOC	Level or loss of consciousness
Lat.	Lateral
Ⓛ	Left
LLQ	Left lower quadrant
LUQ	Left upper quadrant
Lac.	Laceration
MVA	Motor vehicle accident
M/C, MC	Motorcycle
mg	Milligrams
MPH	Miles per hour
N/V/D	Nausea, Vomiting, Diarrhea
NC	Nasal cannula
p̅	After
ped.	Pedestrian
Pt.	Patient
Rad →	Radiates to (i.e. Rad →arm)
R.O.M.	Range of Motion
Ⓡ	Right
RLQ	Right lower quadrant
RUQ	Right upper quadrant
SQ	Subcutaneously
S/R	Strong and regular
s̅	Without
SOB	Shortness of breath
T/C, TC	Traffic collision
TKO	To keep open
Tx	Treatment
VS, vs	Vital Signs
X	Times
7 on 10	Rated as 7 on a scale of 10
=	Equal
°	Degree
l.	Liters
2°	Secondary
≈	Approximately
△	Change
"	Inches
'	Feet
⬆	Increased, elevated, high
⬇	Decreased, diminished, low

THIS FORM MUST BE LEFT AT BASE HOSPITAL

ADVANCED SKILLS EVALUATION FORM

CHECK, OR FILL-IN THE REQUESTED INFORMATION

ICEMA RUN REPORT # _____

	SIZE	# OF ATTEMPTS	SUCCESSFUL*
PATIENT NAME _____			
INTUBATION: ADULT ☐ NASAL ☐ ORAL	_____	_____	☐ YES ☐ NO
☐ PEDIATRIC ORAL	_____	_____	☐ YES ☐ NO
NEEDLE CRICOTHYROTOMY WITH PERTRACH	_____	_____	☐ YES ☐ NO
INTRAOSSEOUS INFUSION SITE: _____	_____	_____	☐ YES ☐ NO

HOW WAS THE PLACEMENT VERIFIED? _____

TRANSCUTANEOUS CARDIAC PACING CAPTURE? ☐ YES ☐ NO HR _____ AMP _____ MAMP

PALPABLE PULSE RATE _____ B/P _____ ATROPINE GIVEN ☐ YES ☐ NO

WAS PULSE OXIMETRY UTILIZED? ☐ YES ☐ NO READING BEFORE TX _____ AFTER TX _____

WAS END TIDAL CO2 DETECTED? ☐ YES ☐ NO READING _____ % OF CO2 DETECTED.

***IF ABOVE PROCEDURE WAS SUCCESSFUL, EXPLAIN PATIENT RESPONSE:**

_____

_____

***IF UNSUCCESSFUL, EXPLAIN WHY:**

_____

_____

_____

FIELD ASSESSMENT / TREATMENT INDICATORS: _____

COMMENTS: _____

_____

PROCEDURE PERFORMED: ☐ PRIOR TO CONTACT ☐ RCF ☐ BASE HOSPITAL ORDER

RECEIVING HOSP. _____ BASE HOSP. _____

RECEIVING M.D. SIGNATURE: _____ DATE: _____

PARAMEDIC SIGNATURE: _____ DATE: _____

THIS SECTION TO BE COMPLETED BY PLN

PATIENT OUTCOME: ☐ DECEASED ☐ ADMITTED ☐ OTHER: _____

☐ TRANSFERRED TO: _____

DOES PLN RECOMMEND FOLLOW-UP BY ICEMA? ☐ YES ☐ NO

HOSPITAL DX: _____

PLN SIGNATURE: _____ DATE: _____

SEX M F U

AGE

ZIP

#PTS 1 2 3 4 5 6 7 8 9 >9

INCIDENT #

RUN DATE

CITY

RUN CODE TO 1 2 3 FROM 1 2 3

OTHER TRANSPORT PROVIDER UNIT — MA MS ME AM SQ E

OTHER ICEMA #

CATEGORY
- T trauma
- C cardiac
- R respiratory
- A amputation
- B behavior/OD
- 5 5150
- U burn
- D domest viol
- E environment
- O obstetric
- P poisoning
- S spinal inj
- M oth medical
- N transfer

MECH. OF INJURY (TRAUMA ONLY)
- M auto/truck-MVA
- SEATBELT Y N U
- C motorcycle
- HELMET Y N U
- G gunshot
- S stabbing
- A assault
- D near-drowning
- F fall>20'
- B bite/sting
- L blunt injury
- T multiple mech.
- P oth penetrating
- O other
- U unknown

PRIOR CARE
- N none
- M medical
- B FD/BLS
- C citizen
- O other
- L law enf.
- A FD/ALS

BASE HOSP

NO CONTACT

RECV HOSP

--TIMES--

CALL RCD

EN ROUTE

ARRIVE

DEPART

ARV DEST

- Y PT REFUSES CARE
- Y RELEASE SIGNED

CARE RENDERED
- F AED
- A Bag-valve mask
- M burn care
- B axial-spinal stabilization
- P CPR/resuscitation
- D decontamination
- E extrication
- C hard collar
- H hot/cold packs
- K KED
- N NP/OP airway
- O OB assist
- X oxygen
- G sand bags
- I snake bite care
- S splint, simple
- T splint, traction
- L suction
- W wound dressing
- U BLS other
- B blood drawn
- D dexstick
- E EKG monitor
- T EKG strip
- F 12 lead EKG
- G McGill forceps
- 1 Meds given IV
- 2 Meds given IO
- 3 Meds given ET
- 4 Meds given PO
- O monitor chest tube
- P needle thoracostomy
- N NG insertion
- C Percutaneous Needle Cric
- Y Approved Device
- H TCP
- V Valsalva maneuver
- U ALS other

MEDICATIONS
- A act. charcoal
- H adenosine
- B albuterol
- J aspirin
- P atropine
- K bretylium
- D dextrose
- 1 diphenhydramine
- 2 dopamine
- E epineph-IV
- Q epineph-SQ
- F furosemide
- G glucagon
- L lidocaine
- R magnesium
- S midazolam
- M morphine
- N naloxone
- 3 nitroglycerine
- W phenylephrine
- C procainade
- 4 sodium bicarb
- V verapamil
- U other med

SPECIAL STUDY
- M medications
- S skills
- O other

IV/IO
- S saline
- L SL

SYS BP
- >90 4
- 70-90 3
- 50-69 2
- <50 1
- 0 0

RESP RATE
- 10-24 4
- 25-35 3
- >35 2
- <10 1
- 0 0

EFFORT
- normal 1
- shallow or retract. or none 0

CAP REFILL
- normal 2
- delayed 1
- none 0

BEST MOTOR
- obedient 6
- purposeful 5
- withdrawal 4
- flexion 3
- extension 2
- none 1

BEST VERBAL
- oriented 5
- confused 4
- inappropriate 3
- incomprehens. 2
- none 1

EYE OPEN
- spontan 4
- to voice 3
- to pain 2
- none 1

GCS/TRS 14-15=5 11-13=4 8-10=3 5-7=2 3-4=1

1ST EKG
- R cardiovert
- D dfib
- N SR
- B SB
- T ST
- V Vfib
- C VT
- D SVT
- I Afib
- L AFL
- E AT
- A AVB
- Y ASY
- O Oth

ATTEMPTS PLACED
- IV 1 2 3+ Y
- IO 1 2 3+ Y
- ET 1 2 3+ Y
- ET N nasal O oral

PT CONDITION
- C change
- N no change

OUTCOME
- C cancelled en route
- D dry run-no pt
- R transport refused
- G transport-ground
- A transport-air
- O obviously dead

WHY SELECTED
- T major trauma
- P patient request
- D diversion
- C closest
- E peds trauma
- R reroute
- O other

ICEMA NO.

ATTENDANT #1 CERT NO

ATTENDANT #2 CERT NO

THIS FORM BY PROVIDER UNIT — MA MS ME AM SQ E

MAKE NO MARKS IN THIS AREA

P3 2906 -350- 10 9 8 7 6 5 4 3 2 1

Scantron asks that you please KEEP CLEAR this product.

FORM NO. F-1612-ICEMA Rev. 10/04

SCANTRON

INYO COUNTY
PUBLIC PROVIDERS:
- Big Pine Fire Dept . . . 034
- Death Valley Nat'l Park . . . 660
- Independence Fire Dept . . . 010
- Lone Pine Fire Dept . . . 046
- Olancha/Cartago Fire Dept . . . 650
- Southern Inyo Fire Protection District . 070

PRIVATE PROVIDERS:
- Liberty Ambulance . . . 206
- Southern Sierra Ambulance . . . 209
- Symons Emergency Specialties . . . 215

HOSPITAL CODES:
- Northern Inyo . . . 79
- Southern Inyo . . . 05
- Desert Springs -Nevada . . . 01
- Humana Sunrise-Nevada . . . 02
- University Med Ctr-Nevada . . . 03
- Valley Hospital-Nevada . . . 04

MONO COUNTY
PUBLIC PROVIDERS:
- Benton Ambulance . . . 105
- Chalfant Valley Fire Dept . . . 012
- Mammoth Lakes Fire Dept . . . 030
- Mono County EMS . . . 103
- USMCWTC NHBC Bridgeport EMS . . . 708
- White Mountain Fire Dist . . . 005

HOSPITAL CODES:
- Mammoth Hospital . . . 08
- Mono Co. Med. Grp. . . . 74
- Carson Tahoe-Nevada . . . 09
- Carson Valley Medical Center-Nevada . 14
- St. Mary's-Nevada . . . 12
- Washoe-Nevada . . . 13

SAN BERNARDINO COUNTY
PUBLIC PROVIDERS:
- Adelanto-SBCO Fire Dept . . . 321
- Apple Valley Fire Dept . . . 331
- Arrowbear Lake CWD . . . 271
- Barstow Fire Prot Dist . . . 361
- Big Bear City Fire & Paramedic Service . . . 291
- Big Bear Lake Fire Dept . . . 281
- CDF Crafton . . . 552
- CDF Highland . . . 541
- CDF Yucaipa . . . 551
- Chino Valley Independent Fire Dist . . . 061
- Colton Fire Dept . . . 211
- Combat Center Fire Dept 29 Palms . . . 451
- Crest Forest Fire Prot. Dist. . . . 025
- Fawnskin-SBCO Fire Dept . . . 049
- Fontana-SBCO Fire Dept . . . 071
- Green Valley Lake SBCO Fire Dept . . . 129
- Havasu Lake-SBCO Fire Dept . . . 118
- Hesperia-SBCO Fire Dept . . . 301
- Joshua Tree Fire Dept . . . 056
- Lake Arrowhead-SBCO Fire Dept . . . 091
- Landers Vol. Fire Dept . . . 019
- Loma Linda Fire Dept . . . 251
- Lucerne Valley-SBCO Fire Dept . . . 111
- Marine Corps Logistics Base Fire & Emer Svc . . . 401
- Montclair Fire Dept . . . 151
- Morongo Valley CSD Fire Dept . . . 461
- Ontario Fire Dept . . . 131
- Rancho Cucamonga Fire Dept . . . 171
- Redlands Fire Dept . . . 261
- Rialto Fire Dept . . . 201
- Running Springs Fire Dept . . . 050
- San Bernardino City Fire Dept . . . 222
- San Manuel Fire Dept . . . 241
- Searles Valley-SBCO Fire Dept . . . 126
- Yucca Valley-SBCO Fire Dept . . . 121
- Twentynine Palms Fire Dept . . . 421
- Upland Fire Dept . . . 161
- Victorville Fire Dept . . . 311
- Wrightwood- SBCO Fire Dept . . . 101
- US Govt Sky Forest USFS Station 11 . . . 476
- US Govt Deer Lick / Running Springs USFS Station 12 . . . 477
- US Govt Rock Camp / Lake Arrowhead USFS Station 13 . . . 478
- US Govt Silverwood / Hesperia USFS Station 14 . . . 479
- US Govt Big Pine Flats / Fawnskin USFS Station 15 . . . 481
- US Govt Big Bear / Fawnskin USFS Station 16 . . . 480
- US Govt Angelus Oaks / Converse USFS Station 17 . . . 473
- US Govt Lucerne Valley USFS Station 19 . . . 474

PRIVATE PROVIDERS:
- AMR R Cucamonga . . . 053
- AMR Redlands & San Bernardino . . . 078
- AMR Victorville . . . 088
- Baker EMS . . . 040
- California Speedway . . . 055

PRIVATE PROVIDERS: (cont'd)
- Desert Ambulance . . . 042
- Morongo Basin Amb . . . 060
- Needles Ambulance . . . 044
- Priority One Medical Transport . . . 054
- Searles Valley Minerals . . . 082

EMS AIRCRAFT
- Calif Hwy Patrol Air . . . 500
- Flight for Life . . . 560
- Guardian Air . . . 520
- Mercy Air . . . 530
- Native American Air . . . 540
- San Bdno Co Sheriff Air . . . 535
- Sierra Lifeflight . . . 590
- Tri-State Care Flight . . . 550

OTHER PROVIDER
- Public . . . 888
- Private . . . 999

HOSPITAL CODES:
- Arrowhead Regional Med Ctr . . . 97
- Barstow Comm . . . 10
- Bear Valley Comm . . . 11
- Chino Valley Med Ctr . . . 25
- Colorado River Med Ctr . . . 27
- Comm Hosp of San Bdno . . . 98
- Desert Valley Hospital . . . 21
- Hi-Desert Med Ctr . . . 31
- Kaiser Permanente . . . 59
- Kindred Hospital Ontario . . . 41
- Loma Linda Comm . . . 68
- Loma Linda U Med Ctr . . . 69
- Mountains Comm . . . 76
- Redlands Comm . . . 91
- San Antonio Comm . . . 96
- St. Bernardine Med Ctr . . . 06
- St. Mary Regional Med Ctr . . . 07
- 29 Palms Marine . . . 29
- Veterans Admin . . . 95
- Victor Vly Comm . . . 18
- Weed Army . . . 19
- No Hosp Contact . . . 89
- Chronic care facil . . . 77
- Out of region hosp . . . 88
- Other destination . . . 99

INCIDENT CITY CODES

INYO COUNTY
- Big Pine . . . 045
- Bishop . . . 050
- Darwin . . . 005
- Death Valley . . . 020
- Furnace Creek . 022
- Independence . 044
- Keeler . . . 004
- Little Lake . . . 032
- Lone Pine . . . 046
- Olancha . . . 030
- Shoshone . . . 060
- Tecopa . . . 062
- Trona area . . . 015
- Inyo Co. Other . . . 069

MONO COUNTY
- Benton . . . 010
- Bridgeport . . . 070
- Chalfant Valley . . . 080
- Coleville . . . 096
- June Lake . . . 092
- Lee Vining . . . 082
- Long Valley . . . 085
- Mammoth Lakes . . 090
- Mono City . . . 091
- Paradise . . . 093
- Swall Meadows . . . 094
- Tioga Pass . . . 098
- Topaz Lake . . . 097
- USMC-MWTC . . . 083
- Walker . . . 095
- Mono Co. Other . . 099

SAN BERNARDINO COUNTY

WEST VALLEY AREA 1
- Mount Baldy . . . 331
- Rancho Cucamong . 110
- San Antonio Hts . 113
- Upland . . . 150

CHINO AREA 2
- Chino . . . 100
- Chino Hills . . . 101
- Montclair . . . 130

ONTARIO AREA 3
- Creekside . . . 161
- Guasti . . . 160
- Ontario . . . 140

FONTANA AREA 4
- Bloomington . . . 200
- Crestmore . . . 205
- Fontana . . . 120
- Lytle Creek . . . 332

RIALTO AREA 5
- Rialto . . . 270

SAN BERNARDINO AREA 6
- Colton . . . 210
- Del Rosa . . . 282
- Devore . . . 255
- Highland . . . 230
- Keenbrook . . . 336
- Muscoy . . . 250
- San Bernardino . 280
- Verdemont . . . 940

GRAND TERRACE AREA 7
- East Highlands . 235
- Grand terrace . . . 220
- San Timoteo Cn . 215

REDLANDS AREA 8
- Angelus Oaks . . 360
- Barton Flats . . . 361
- Camp Angeles . 362
- Crafton . . . 266
- Forest Falls . . . 350
- Mentone . . . 265
- Mountain Home 353
- Oak Glen . . . 295
- Redlands . . . 260
- Seven Oaks . . . 363
- Yucaipa . . . 290

LOMA LINDA AREA 9
- Bryn Mawr . . . 245
- Loma Linda . . . 240

CRESTLINE AREA 10
- Cedar Pines Pk . 312
- Crest Forest . . . 313
- Crestline . . . 310
- Vly of Enchant . . 311

SAN BERNARDINO AREA 11
- Arrowhead Springs . 281

VICTORVILLE AREA 12
- Adelanto . . . 400
- Apple Valley . . . 410
- Baldy Mesa . . . 403
- Desert Knoll . . . 411
- El Mirage . . . 404
- Lucerne Valley . 425
- Oro Grande . . . 471
- Silver Lakes . . . 476
- Spring Vly Lake 412
- Summit . . . 333
- Victorville . . . 470

HIGH DESERT AREA 13
- Amboy . . . 520
- Atolia . . . 506
- Bagdad . . . 521
- Barstow . . . 420
- Calico Ghost Twn . 405
- Daggett . . . 430
- Fort Irwin . . . 800
- Helendale . . . 475
- Hinkley . . . 450
- Kelso . . . 529
- Kramer . . . 528
- Lenwood . . . 460
- Lockhart . . . 499
- Ludlow . . . 522
- Newberry . . . 431
- Paradise Sprngs . . 598
- Pioneer Point . . 505
- Red Mountain . . 503
- Ridgecrest . . . 599
- Yermo . . . 480

YUCCA VALLEY AREA 14
- Johnson Valley . 621
- Joshua Tree . . . 600
- Morongo Valley . 620
- Pioneer Town . . 622
- Rimrock . . . 623
- Twentynine Plm 610
- Wonder Valley . 626
- Yucca Valley . . . 625

LANDERS AREA 15
- Landers . . . 624

WRIGHTWOOD AREA 16
- Cajon Junctn . . . 334
- Phelan . . . 401
- Pinon Hills . . . 402
- West Cajon . . . 335
- Wrightwood . . . 330

HIGH DESERT AREA 17
- Hesperia . . . 440

MOUNTAINS AREA 18
- Blue Jay . . . 323
- Cedar Glen . . . 321
- Crest Park . . . 324
- Deer Lodge Pk . 322
- Lake Arrowhead . 320
- Rim Forest . . . 314
- Sky Forest . . . 325
- Twin Peaks . . . 315

MOUNTAINS AREA 19
- Arrowbear Lake . 342
- Fredalba . . . 341
- Green Valley . . . 343
- Running Springs . . . 340
- Snow Valley . . . 306

BIG BEAR AREA 20
- Baldwin Lk Vill . . 304
- Big Bear City . . . 300
- Big Bear Lake . . 301
- Erwin Lake . . . 303
- Fawnskin . . . 302
- Lake Williams . . 308
- Moonridge . . . 305
- Sugarloaf . . . 307

NEEDLES AREA 22
- Big River . . . 712
- Cadiz . . . 611
- Crossroads . . . 713
- Earp . . . 714
- Essex . . . 705
- Fenner . . . 704
- Goffs . . . 703
- Havasu Lake . . 710
- Homer . . . 701
- Needles . . . 700
- Parker Dam . . . 711
- Rice . . . 798
- Searchlight . . . 702
- Vidal . . . 799

BAKER AREA 23
- Afton . . . 530
- Baker . . . 531
- Cima . . . 532
- Ivanpah . . . 533
- Mountain Pass . 534
- Nipton . . . 535
- Wheaton Sprgs 536

TRONA AREA 24
- Argus . . . 502
- Boron/Borosol . 498
- Searles Vly . . . 504
- Trona . . . 500
- Westend . . . 501

SAN BERNARDINO COUNTY
- Other . . . 950

CARE OF MINORS IN THE FIELD

PURPOSE
To provide guidelines for EMS personnel for treatment and/or transport of minors in the field.

AUTHORITY
California Welfare and Institutions Code Section 625, Civil Code, sections 25, 34, and 62

DEFINITIONS

Consent: Except for circumstances specifically prescribed by law, a minor is not legally competent to consent to, or refuse medical care.

Voluntary consent: treatment and/or transport of a minor shall be with the verbal or written consent of the parent or legal representative.

Involuntary consent: in the absence of a parent or legal representative, emergency treatment and/or transport may be initiated without consent.

Minor: Any person under 18 years of age

Minor not requiring parental consent: a person who;

Is decreed by the court as an emancipated minor
Has a medical emergency and parent is not available
Is married or previously married
Is on active duty in the military
Is pregnant and requires care related to the pregnancy
Is twelve years or older and in need of care for rape and/or sexual assault
Is twelve years or older and in need of care for a contagious reportable disease or condition, or for substance abuse

Legal Representative: A person who is granted custody or conservatorship of another person

Emergency: An unforeseen condition or situation in which the individual has need for immediate medical attention, or where the potential for immediate medical attention is perceived by EMS personnel or a public safety agency

PROCEDURE

Treatment and/or Transport of Minor

1. For all ill or injured minors under the age of nine (9) years, Base Hospital contact is required before leaving scene.
2. In the absence of a parent or legal representative, minors with an emergency condition shall be treated and transported to the medical facility most appropriate to the needs of the patient.
3. In the absence of a parent or legal representative, minors with a non-emergency condition require EMS personnel to make reasonable effort to contact a parent or legal representative before initiating treatment and/or transport. If a parent or legal representative cannot be reached and minor is transported, EMS personnel shall make every effort to inform the parent or legal representative of where the minor has been transported, and request that law enforcement accompany the minor patient to the hospital.

Minor Not Requiring Immediate Treatment and/or Transport

1. A minor evaluated by EMS personnel and determined not to be injured, to have sustained only minor injuries, or to have an illness or injury not requiring immediate treatment and/or transportation, may be released to:
   a. Parent or legal representative
   b. Designated care giver over 18 years of age
   c. Law Enforcement
2. EMS personnel shall document on the patient care report to whom the minor was released.

Minor Attempting to Refuse Indicated Care

1. Contact Base Hospital
2. Attempt to contact parent or legal representative for permission to treat and/or transport
3. Contact Law Enforcement and request minor to be taken into temporary custody for treatment and/or transport (only necessary in the event parents or legal representative cannot be contacted).

APPROVED:

ICEMA Medical Director — Date 2-28-06

San Bernardino Co. Health Officer — Date MAR 0 8 2006

Inyo Co. Health Officer — Date 3/16/06

Mono Co. Health Officer — Date 3/21/06

ICEMA Executive Director — Date 3/24/06

ORGAN DONOR INFORMATION

PURPOSE

To comply with state legislation requiring EMS field personnel to search for organ donor information on adult patients for whom death appears imminent.

AUTHORITY

California Health and Safety Code, Section 7152.5, b (3) and c, d, and e

DEFINITIONS

Reasonable Search: A brief attempt by Emergency Medical Services field personnel to locate documentation that may identify a patient as a potential organ donor, or one who has refused to make an anatomical gift. This search shall be limited to a wallet or purse that is on or near the individual to locate a driver's license or other identification card with this information. A reasonable search shall not take precedence over patient care/treatment.

Imminent Death: A condition wherein illness or injuries are of such severity that in the opinion of Emergency Medical Services personnel, death is likely to occur before the patient arrives at the receiving hospital.

POLICY

Existing law provides that any individual who is at least 18 years of age may make an anatomical gift, and sets forth procedures for making that anatomical gift, including signing a donor card that may be attached to a driver's license or identification card.

1. When emergency medical services (EMS) personnel encounter an unconscious adult patient for whom it appears death is imminent a reasonable search of the patient's belonging should be made to determine if the individual carries information indicating status as an organ donor. This search shall not interfere with patient care or transport. Any inventory of victim's personal effects should be on the patient care record and signed by the person who receives the patient.
2. All EMS personnel shall notify the receiving hospital if organ donor information is discovered.
3. Any organ donor document discovered should be transported to the receiving hospital with the patient unless the investigating law enforcement officer requests the document. In the event that no transport is made, any document should remain with the patient.
4. Field personnel should briefly note the results of the search, notification of hospital, and witness name(s), on the ICEMA Patient Care Report.
5. No search is to be made by field personnel after the patient has expired.

LOCAL MEDICAL EMERGENCY

PURPOSE

To provide guidelines to pre-hospital care providers and personnel regarding the treatment and transportation of patients during a declared Local Medical Emergency (see definition).

POLICY

It shall be the policy of pre-hospital care providers and personnel to follow the procedures and guidelines outlined below in regards to the treatment and transportation of patients during a declared Local Medical Emergency.

DEFINITION

Local Medical Emergency: For the purposes of this policy, a Local medical Emergency shall exist when a "local emergency", as that term is used in government Code Section 8630, has been proclaimed by the governing body of a city or the county, or by an official so designated by ordinance.

ENACTMENT OF PROTOCOL

The following procedures shall apply during a Local Medical Emergency:

1. A public safety agency of the affected jurisdiction shall notify the County Communications Center of the proclamation of a local emergency, and shall provide information specifying the geographical area that the proclamation affects.
2. The Communications Center shall notify:
   a. The County Health Officer/Designee;
   b. The County Sheriff's Department;
   c. Area pre-hospital provider agencies; and
   d. Area hospitals
3. This protocol shall remain in effect for the duration of the declared Local Medical Emergency or until rescinded by the County Health Officer (Operational Area Medical Coordinator) or his/her designee.

MEDICAL CONTROL

1. ALS and BLS personnel may function within their Scope of Practice as established in the standard Practice Protocols without base hospital contact
2. No care will be given unless the scene is secured, and safe for EMS personnel
3. When possible patients should be transported to the most appropriate facility (outside the affected area), or staging area
4. Transporting agencies may utilize BLS units for patient transport as dictated by transport resource availability. In cases where no ambulance units are available, personnel will utilize the most appropriate method of transportation at their disposal
5. Patients too unstable to be transported outside the affected area should be transferred to the closest secured appropriate facility
6. County Communications Center should be contacted on the MED NET frequency for patient destination by the transporting unit

7. Base Hospital contact criteria outlined in protocol #14009 is suspended. When possible the receiving facility should be contacted with following information once enroute:
   a. ETA
   b. Number of patients
   c. Patient status: Immediate, delayed or minor
   d. Brief description of injury
   e. Treatment initiated

DOCUMENTATION

Provider and transporting agencies may utilize approved triage tags as the minimum documentation requirement. The following conditions will apply:

1. One corner to be kept by the jurisdictional public safety agency. A patient transport log will also be kept indicating time, incident number, patient number (triage tag), and receiving facility
2. One corner to be retained by the transporting agency. A patient log will also be maintained indicating time, incident number, patient number (triage tag), and receiving facility
3. Remaining portion of triage tag to accompany patient to receiving facility which is to be entered into the patient's medical record
4. All Radio communication Failure reports and trauma medic and endotracheal intubation evaluation forms may be suspended for duration of the Local Medical Emergency

All refusal of service will accompany ALS run report and signature of patient as scene safety allows

COUNTY COMMUNICATIONS CENTER

County communications Center will conduct a survey of the overall capability of each hospital to support patients in accordance with immediate and delayed categories. This information will be coordinated with appropriate fire/rescue zone dispatch centers and medical unit leaders in the field as needed

RESPONSIBILITIES OF THE RECEIVING FACILITIES

1. Receiving facilities upon notification by the County Communications Center of a declared Local Medical Emergency will provide hospital bed availability, and Emergency Department capabilities for immediate and delayed patients
2. Receiving facilities will provide the County Communications Center with hospital status every four hours, upon request, or when capacities are reached
3. Criteria for Hospital diversions are suspended
4. It is strongly recommended that receiving facilities establish a triage area in order to evaluate incoming emergency patients
5. In the event that incoming patients overload the service delivery capacity of the receiving hospital it is recommended that the hospital consider implementing their disaster plan
6. Saturated hospitals may request evacuation of stable in-patients. Movement of these patients should be coordinated by County Communications Center and in accordance with Armed Services Medical Regulation Office (ASMRO) system categories

DENIAL OF PREHOSPITAL CARE CERTIFICATION

PURPOSE

To establish local policies for the denial of an application for initial or renewal certification for prehospital care personnel

POLICY

The Medical Director shall adhere to the following guidelines in considering denial of an application either for prehospital care certification or for renewal of prehospital care certification, and in ensuring appropriate due process to applicants where denial of certification is recommended:

General Considerations for Denial

1. Gross negligence in providing prehosptial care services
2. Repeated negligent acts in the provision of prehospital care services
3. Incompetence as a prehospital care provider
4. The commission of any fraudulent, dishonest, or corrupt act which is substantially related to the qualifications, functions, and duties of prehospital personnel.
5. Conviction of any crime which is substantially related to the qualifications, functions, and duties of prehospital personnel.
6. Violating or attempting to violate directly or indirectly assisting in or abetting the violation of, or conspiring to violate, any provision of the California Health and Safety Code or the regulations promulgated by the State EMS Authority pertaining to prehospital care personnel.
7. Violating or attempting to violate any federal or state statute or regulation which regulates narcotic, dangerous drugs, or controlled substances.
8. Addiction to the excessive use of, or the misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances.
9. Functioning outside the supervision of medical control in the prehospital field care system except as authorized by any other license or certification.
10. Demonstration of irrational behavior or occurrence of a physical disability to the extent that a reasonable and prudent person would have reasonable cause to believe that the ability to perform the prehospital care duties normally expected may be impaired.

Specific Cases Where Denial is Strongly Indicated

1. The applicant is required under Section 290 of the Penal Code to register as a sex offender for any offense involving force, duress, threat, or intimidation.
2. The applicant habitually or excessively uses or is addicted to narcotics, dangerous drugs, or alcohol, or has been convicted during the preceding seven years of any offense relating to the use, sale, possession, or transportation of narcotics, addictive or dangerous drugs.
3. The applicant has been convicted during the preceding seven (7) years of any offense punishable as a felony and involving force, violence, threat, or intimidation, or has been convicted of theft during that period.
4. The applicant has knowingly falsified or failed to disclose a material fact in his/her application.
5. The applicant is found to have more than one misdemeanor within the preceding seven (7) years on record which is substantially related to the qualifications, functions, and duties of prehospital care personnel.

Basis for Due Process

An applicant who has been initially denied prehospital care certification or renewal of such certification is entitled, with limited exception, to contest that action in accordance with the "Emergency Medical Services Personnel Certification Review Process Guidelines" found in Chapter 6 of Division 9, Title 22, California Code of Regulations. Local EMS agency staff shall assure that all such applicants are apprised of this due process right. This right, however, is not available to any applicant whose certification denial is based on one or more of the following grounds:

1. Failure to pass a certification examination or to meet any other requirement(s) for certification or continuation of certification/accreditation
2. Revocation, suspension, or denial of an applicant's prehospital care certification by any local EMS agency medical director prior to the existing application process
3. Fraud in the procurement or attempted procurement of any prehospital care certification relating to eligibility in accordance with Section 1798.200 of the Health and Safety Code

GUIDELINES ON APPLYING PATIENT RESTRAINTS

PURPOSE

To provide guidelines on the use of restraints in the field or during transport for patients who are violent or potentially violent, or who may harm themselves or others

AUTHORITY

California Code of Regulations, Title 22, Sections 1000075 and 10000159. Welfare and Institutions Code 5150. California Administrative Code, Title 13, Sections 1103.2 Health and Safety Code, Section 1798.6

PRINCIPLES

1. The safety of the patient, community and responding personnel is of paramount concern when following this policy.
2. Restraints are to be used only when necessary in situations where the patient is potentially violent and is exhibiting behavior that is dangerous to self or others.
3. EMS personnel must consider that aggressive or violent behavior may be a symptom of medical conditions such as head trauma, alcohol, drug-related problems, metabolic disorders, stress and psychiatric disorders.
4. The method of restraint used shall allow for adequate monitoring of vital signs and shall not restrict the ability to protect the patient's airway or compromise neurological or vascular status.
5. Restraints should be applied by law enforcement whenever possible. If applied, an officer is required to remain available at the scene or during transport to remove or adjust the restraints for patient safety.
6. This policy is not intended to negate the need for law-enforcement personnel to use appropriate restraint equipment that is approved by their respective agency to establish scene-management control.

PROCEDURE

The following procedures should guide EMS personnel in the application of restraints and the monitoring of the restrained patient.

1. Restraint equipment must be either padded leather restraints or soft restraints (e.g., posey, Velcro or seat-belt type). Both methods must allow for quick release.
2. EMS personnel shall **not** apply following forms of restraint:
   a. Hard plastic ties, any restraint device requiring a key to remove, hand cuffs or hobble restraints
   b. Backboard, scoop stretcher or flat as a "sandwich" restraint
   c. Restraining a patient's hands and feet behind the patient (e.g., hog-tying)
   d. Methods or other materials applied in a manner that could cause vascular or neurological compromise
3. Restraint equipment applied by law enforcement (handcuffs, plastic ties or "hobble" restraints) must provide sufficient slack in the restraint device to allow the patient to straighten the abdomen and chest, and to take full tidal volume breaths.
4. Restraint devices applied by law enforcement require the officer's continued presence to ensure patient and scene-management safety. The officer shall accompany the patient in the ambulance or follow by driving in tandem with the ambulance on a predetermined route. A method to alert the officer of any problems that may develop during transport should be discussed prior to leaving the scene.
5. Patients should be transported in a supine position if at all possible. EMS personnel must ensure that the patient's position does not compromise respiratory/circulatory systems, or does not preclude any necessary medical intervention to protect the patient's airway should vomiting occur.

CONTROLLED SUBSTANCE POLICY

PURPOSE

To comply with State and Federal regulations regarding procurement, storage, accountability, administration and destruction of controlled substances utilized by paramedic agencies that participate in the San Bernardino, Inyo and Mono Counties controlled substance program utilizing the San Bernardino County Health Officer's DEA number to obtain their controlled substances.

For the ALS pre-hospital provider agencies choosing not to participate in this program, the logs and tracking mechanisms enclosed may be utilized at your discretion. However, each ALS provider must provide ICEMA with a copy of their internal policy for their Controlled Substance Program.

All providers should obtain a copy of *"Physicians Manual---An Informational Outline of the Controlled Substances Act of 1970"* (Revised March 1990). Copies can be ordered through the Riverside DEA office (951) 328-6200 or (951) 328-6201.

PROCEDURE

Daily Log

1. All controlled substances stored on an ALS unit shall be counted each day or shift.
2. The paramedic who is accepting responsibility (coming on duty) for the controlled substance shall examine the controlled substance for signs of damage, expiration date and document in the appropriate place on the Daily Log.
3. The paramedic relinquishing responsibility will co-sign in the indicated area. If a paramedic is on duty longer than twenty-four hours, the co-signer on the subsequent days shall be another paramedic or a superior (either a fire captain or field supervisor).
4. If a controlled substance is used or wasted during the shift, the following must be noted on the Daily Log:
   a. Name of patient
   b. Time of incident
   c. Patient care report incident number
   d. Name of paramedic administering controlled substance
   e. Amount of medication given and amount wasted
5. The **original** Daily Log shall be sent to ICEMA on a monthly basis with copies of each patient care report utilizing controlled substances.
6. A **photocopy** of the Daily Log will be maintained by the ALS provider agency for two years.

Monthly Log

1. All controlled substances stored in an agency safe must be counted:
   a. At the beginning of every month
   b. Whenever a controlled substance is removed from the safe
   c. Whenever a controlled substance is placed into the safe
2. The designated controlled substance coordinator shall coordinate the replacement/removal procedures for controlled substances from their inventory.
3. When a controlled substance is replaced, the following must be noted on the Monthly Log:
   a. Name of patient

b. Time and date of incident
c. Patient care report incident number
d. Amount of medication given and wasted
e. Signature of paramedic replacing controlled substance

4. The designated controlled substance coordinator /designee will co-sign for all replacements.
5. The designated controlled substance coordinator /designee signature indicates:
   a. The paramedic completed the form.
   b. The dose given and the amount wasted was documented and agrees with the information on the patient care report.
   c. The dispensed controlled substance was given to the paramedic and placed into the ALS unit drug box and secured with a double locking device.
6. The original Monthly Log shall be sent to ICEMA each month.
7. A photocopy of the Monthly Log will be maintained by the ALS provider agency for two years.

Storage of Controlled Substances

1. Agency Safe must have a double locking mechanism and be maintained at the physical location listed on the DEA Controlled Substance Registration Certificate.
2. Access to the Agency Safe shall be limited to the designated controlled substance coordinator/designee.
3. Controlled substances stored on ALS Units must have a double locking mechanism with access to the controlled substance limited to the assigned paramedic.

Documentation of Damaged or Expired Controlled Substances

1. The designated controlled substance coordinator/designee shall be notified immediately when a controlled substance has been damaged or expired.
2. An explanation of the event must be documented on the appropriate log.
3. A written explanation of the event shall be sent to the ICEMA with the Daily and Monthly Logs on agency letterhead.

ALS Agency Participation in the ICEMA Controlled Substance Program

1. A written request should be sent to ICEMA requesting participation in this program approximately three months prior to expected start date. This written request should include:
   a. Name of the designated controlled substance coordinator who will be responsible for the ALS agency controlled substance program
   b. Copy of internal policy for Controlled Substance Program adherence
   c. Address of where the supply of controlled substances will be stored. This address will be listed on the DEA registration certificate.
   d. Name and address of vendor where controlled substances will be ordered
2. A *Controlled Substance Registration Certificate* and 222 order forms will be issued directly to the ALS agency provider by the DEA. Upon receipt, the ALS provider must immediately surrender to ICEMA the 222 forms as well as a copy of the *Controlled Substance Registration Certificate.*
3. To order Morphine Sulfate, a letter on Agency letterhead signed by the designated controlled substance coordinator will be sent to ICEMA listing the amount of morphine to be ordered. ICEMA will be responsible for completing the 222 Form and obtaining the signature of the Public Health Officer.
4. Midazolam may be ordered directly through the identified vendor by an ALS agency provider.
5. ICEMA will send an authorization letter to the identified vendor indicating the request for an ALS agency to

purchase controlled substances.

6. ICEMA must be notified in writing if the ALS provider agency chooses to change vendors.
7. ICEMA must be notified in writing when there is a change in the designated controlled substance coordinator/designee.
8. The designated controlled substance coordinator/designee shall be notified immediately when a controlled substance shipment arrives. If the coordinator is unavailable the shipment may be signed for by an employee of the ALS provider agency upon arrival and immediately stored in a secure area. The shipment should be inspected for broken or compromised products.
9. If a product appears broken, damaged or compromised in any way, return it to the vendor along with **DEA Form 106** (Report of Theft or Loss of Controlled Substance) in quadruplicate. Forward the original and duplicate to the Riverside DEA office, **Attention: Lisa Young, within forty-eight hours of occurrence**. Retain the triplicate copy for your records and forward the quadruplicate copy to ICEMA.
10. The disposal of damaged or compromised controlled substances should be preformed as directed by the vendor.
11. Agencies may not borrow controlled substances without prior authorization from the San Bernardino County Health Officer and ICEMA.
12. The San Bernardino County Health Officer and ICEMA may initiate an investigation into an ALS provider agency controlled substance program at any time.

APPROVED:

ICEMA Medical Director — Date: 2-28-06

San Bernardino Co. Health Officer — Date: MAR 0 8 2006

Inyo Co. Health Officer — Date: 3/16/06

Mono Co. Health Officer — Date: 3/2/06

ICEMA Executive Director — Date: 3/23/06

DOWN LICENSING/CLOSURE, LICENSURE CHANGES 9-1-1 RECEIVING HOSPITALS

PURPOSE

To establish a policy and procedure for 9-1-1 receiving hospitals to down-license or close emergency departments or identified specialized services and provide a mechanism for ICEMA to evaluate and report on the potential impact on the EMS system within the region.

AUTHORITY

California Code of Regulations 70105(a), 70107(a), 70107(a)(12), 70351(a), 70351(b)(1), 70701(a)(4), Health & Safety Code Section 10017(d), Section 1300.

PRINCIPLES

1. Hospitals with a basic or comprehensive emergency department permit provide a unique service and an important link to the community in which they are located. In certain instances, the withdrawal or reduction of these services may have a profound impact on the emergency medical services available in their area and to the community at large.
2. Every effort should be made to ensure that emergency medical services considered essential be continued until emergency care can be provided by other facilities or until prehospital care providers can adjust deployment of resources to accommodate anticipated needs.
3. The Emergency Medical Services Agency (ICEMA) should have sufficient time and opportunity to examine the impact that down-licensing or closure of an emergency department will have on a community before any changes are finalized. Such an examination shall be referred to as an EMS Impact Evaluation.
4. Hospitals can be prioritized utilizing objective criteria, referred to as the EMS Impact Evaluation Rating Instrument, to determine the relative level of essential value a hospital has within the system. This rating can be used to ascertain whether ICEMA will request the Licensing and certification Division, operating as agents of the State Department of Health Services, to delay approval of a request to down license or to close an emergency department or the specialized services outlined in Principle No. 3.

PROCEDURE

1. Hospital shall submit an application to the Licensing and Certification Division of the State Department of Health Services for approval prior to down licensing or closing its emergency department or one of the specialized services outlined in Principle No. 3.
2. The Licensing and Certification Division shall contact ICEMA in writing within five working days to request an EMS Impact Evaluation.
3. ICEMA shall notify all appropriate health care providers by mail of proposed down-licensing/closure, or licensure changes.
4. ICEMA, in consultation with appropriate health care providers, shall complete an EMS Impact Evaluation and respond to the Licensing and Certification Division within 25 calendar days of receipt of the request as follows:
   a. If ICEMA determines that additional time is needed to allow for EMS system reconfiguration or planning to occur in order to accommodate the license change requested by the hospital, a written request for up to an additional 60-calendar-day delay in responding to the hospital's application may be requested by ICEMA and shall be considered by Licensing and Certification.

b. If ICEMA determines that approval of the application would have either no impact or a negligible impact on the EMS system, a written statement to that effect shall be submitted.

5. Upon receipt of the written response from ICEMA pursuant to 3b or at the closure of the 60-calendar-day delay requested pursuant to 3a, the Licensing and Certification Division shall notify hospital, in writing, that its application is approved, provided that all other appropriate licensing requirements are met.
6. If ICEMA determines that the down-licensing or closure of a hospital emergency department or the closing of obstetrical, neurosurgical, burn services, or neonatal intensive care units will significantly impact the EMS system, ICEMA shall establish the reason or reasons a hospital has applied to do so and shall attempt to determine whether any system changes may be implemented to either maintain the hospital service within the system or develop strategies for accommodating the loss of the emergency department, or other identified specialized service to the system.
7. If at any time Licensing and Certification issues an approval of closure, down license, or service reduction prior to ICEMA completing its EMS system re-engineering, prior notification shall be provided to ICEMA.

SAN BERNARDINO COUNTY HOSPITAL DIVERSION POLICY

AUTHORITY
Health and Safety Code, Division 2.5, Chapter 6, Section 1798.101a (1), 1798.102, and 1798.170: The local EMS agency may develop triage and transfer protocols to facilitate prompt delivery of patients to appropriate designated facilities within and without its area of jurisdiction.

PURPOSE
ICEMA recognizes that emergency departments may not, at times, be able to accept patients and therefore adopts the following policy to provide structure to the diversion process to minimize adverse effects on patient care and the EMS system.

OBJECTIVES

- To assure transportation of 9-1-1 EMS patients to the closest most appropriate hospital.
- To provide a mechanism for a receiving hospital to request diversion
- To assure that EMS ambulances are not unreasonably removed from their areas of primary response.

POLICY
Diversion is a medical decision dependent upon the ability to provide safe and efficient patient care. Final authority relating to destination of a 9-1-1 ambulance rests with the Base Hospital physician.

This policy shall be utilized by receiving hospitals to request diversion of 9-1-1 ambulances when the hospital is temporarily not equipped and/or prepared to care for additional ambulance patients. A hospital's request to divert shall be made by the attending emergency department physician in consultation with the hospital administrative officer.

Hospitals shall maintain a current diversion policy consistent with ICEMA policy on file with and approved by ICEMA. ICEMA may perform unannounced site visits to hospitals on diversion status to ensure compliance with this policy.

EXCEPTIONS
Diversion requests will be honored, based upon available system resources, with the following exceptions:

1. A patient(s) in an ambulance on hospital property cannot be diverted.
2. Basic Life Support (BLS) units may not be diverted.
3. Patients exhibiting unmanageable problems, e.g. unmanageable airway, uncontrolled hemorrhage, cardio pulmonary arrest, in the field shall be transported to the closest appropriate hospital regardless of diversion status.
4. There is no ED diversion in the geographical areas serviced by Barstow Community Hospital, Bear Valley Community Hospital, Colorado River Medical Center, Hi- Desert Medical Center and Mountains Community Hospital.
5. If the three (3) most accessible hospitals within an incident location are on diversion, a diversion request will not be honored. The patient(s) must be transported to one of the three closest appropriate/requested receiving hospital regardless of diversion status.
6. In San Bernardino County, patients meeting Trauma Triage Criteria (Protocol Reference #8010 (Adult) and #8012 (Pediatric) shall only be diverted to another Trauma Center. In areas greater than thirty (30) minutes from a Trauma Center, contact a Trauma Base Hospital or assigned Base Hospital, if unable to access a

Trauma Center, for medical control and destination decision.

7. Patients enroute to a specific hospital for a specific pre-arranged service, e.g. helipad use, CT/MRI, angiography, direct admission or interfacility transfer or high-risk OB are not subject to diversion.

PROCEDURE

1. A Base Hospital on diversion shall continue to provide on-line medical control. The only exception is a declaration of an Internal Disaster affecting the Base Hospital's ability to provide on-line medical control.
2. Diversion status shall be reported via the Reddi-Net system or another established mechanism as outlined in the hospital diversion plan. The approved diversion categories are:

   a. **ED Diversion**: The hospital's resources are fully committed as determined by the ED attending physician in consultation with the hospital administrative officer and are not expected to become available during the next two (2) hours. ED diversion shall automatically expire at the end of a two (2) hour period and a hospital shall remain open for an additional two (2) hours. The hospital may request an extension of ED diversion if three (3) out of three (3) of the following criteria are met in Category One and two (2) out of three (3) criteria are met in Category Two.

      1) Category One - Two-hour extension. Hospital will notify ICEMA via ReddiNet.
         a) Increase in ambulance traffic resulting in one (1) patient remaining in prehospital provider care greater than twenty (20) minutes without an ED bed assignment
         b) Thirty percent (30%) of ED beds are occupied by admitted patients greater than four (4) hours
         c) All ED beds, including monitored beds, are occupied

      2) Category Two - Extended Diversion. Hospital CEO/designee will notify ICEMA on an hourly basis via ReddiNet.
         a) Increase in ambulance traffic resulting in one (1) patient remaining in prehospital provider care greater than sixty (60) minutes without an ED bed assignment
         b) Fifty percent (50%) of ED beds are occupied by admitted patients greater than six (6) hours.
         c) No available surgery suites available with consideration given to canceling elective surgeries,

   b. **Neuro Diversion**: The hospital is unable to provide access to a CT scanner.

   c. **Trauma Diversion**: (Trauma Centers only): Trauma team resources are fully committed and are not available for incoming patients meeting trauma triage criteria. ***When both Trauma Centers are on Trauma Diversion both Trauma Centers shall accept trauma patients.***

   d. **Internal Disaster**: Applies only to physical plant breakdown threatening the ED or significant patient services e.g. bomb threat, earthquake damage, hazardous materials exposure, terrorist activity or an incident involving the safety and/or security of a facility. In these cases, the hospital administration must immediately notify ICEMA and DHS after declaring an Internal Disaster. ***THIS CATEGORY SHALL NOT BE USED FOR STAFFING ISSUES.***

APPROVED:

_____ _____

EMS Medical Director Date San Bernardino Co. Health Officer Date

_____

ICEMA Executive Director Date

SAN BERNARDINO COUNTY
AMBULANCE MUTUAL AID POLICY

PURPOSE

To provide guidance for the utilization of ambulance resources in San Bernardino County designated operating areas whenever the resources of the permitted provider are not adequate to care for the number of victims involved at an incident, a normal level of stabilization and care cannot be achieved until additional resources are available at the scene, and the situation is not manageable by the routine Emergency Medical Services communication system.

POLICY

All responding providers will utilize 800 MHz designated talk group during an MCI to communicate with the Communications Center once the system is fully implemented. In areas where the 800 MHz system is not fully operational, the HEAR radio systems will be used for the coordination of MCIs.

All hospitals shall provide continuous monitoring of the radio.

NOTE: Multi-Casualty Incident Operational Procedure (at the scene): All personnel at the scene will follow the general procedures outlined in the Multi-Casualty Incident Operational Procedure, Reference #12001.

DEFINITIONS

Incident Commander: The Incident Commander is responsible for the overall management of the incident. On most incidents the command activity is carried out by a single Incident Commander.

Dispatch Center: A facility from which resources are directly assigned to an incident.

Dedicated Stand-by: (Assigned Resources) An ambulance that is requested to stage in an area and remain dedicated to that area.

Non-dedicated Stand-by: (Available Resources) An ambulance that is requested to stage in an area that may leave the staging area if dispatched to a 911 call.

Permitted Provider: An ambulance provider who has a current permit issued by the County Health Officer to provide ambulance service in San Bernardino County.

Exempt "201" Ambulance Provider: A city or fire district, which qualifies under the provisions of Health and Safety Code section 1797.201 as having continuously provided emergency ambulance services within its jurisdiction since on or before June 1, 1980.

PROCEDURE

Ambulance Providers

The following procedure is applicable to mutual aid requests for dedicated ambulances:

The permitted provider of the EMS ambulance operating area in which the incident occurs will be responsible for medical mutual aid requests to the **closest** provider permitted to provide ambulance services within San Bernardino County at the required level, non-permitted ambulance provider agencies located outside of San Bernardino County with whom the San Bernardino County permitted provider has an **approved** mutual aid agreement, or exempt 201 ambulance provider at the level requested by the Incident Commander. The ambulance provider is authorized to request up to five (5) additional ambulances from outside their operating area without notifying the dispatch center for the operational area (San Bernardino County Communications Center). These

ambulances must be on scene in urban/suburban areas within fifteen (15) minutes of receipt of call from the dispatch center. In rural and wilderness areas, the ambulances must be on scene within the standard response time.

If the ambulance provider is unable to garner sufficient resources to meet the needs within an estimated time of arrival of fifteen (15) minutes, further requests for resources will be directed to the San Bernardino County Communications Center. The San Bernardino County Communications Center will coordinate the requests for further ambulance mutual aid.

San Bernardino County Communications Center

Upon receiving notification of a request that results in a request for additional resources, the County Communication Center is to immediately contact the County Health Officer or the duty officer and the EMS Agency. If required, the Health Officer and a representative of the EMS Agency are to proceed to the County Communication Center to commence implementation of the MCI. If presence of Health Department personnel is not required for coordination of the resources, the County Communication Center will implement the plan directly as follows:

1. Initial Scene Report:
   Obtain the type of incident, number of casualties, types of injuries and the incident radio frequency from the incident commander.
2. Bed Inventory:
   a. Advise all hospitals in the affected and adjacent areas and conduct a bed inventory within the area of the incident. This inventory shall include the availability of burn and trauma beds, and emergency room capabilities.
   b. All hospital inventories shall be accomplished by radio, except where indicated on the zone sheet.

1. Patient Distribution and Transportation:
   a. Casualties shall be distributed evenly to the hospitals, taking care not to overload any one facility. Distribution should also take into account trauma center operations and hospitals with specialized abilities.
   b. Appropriate transportation of casualties shall be arranged and dispatched in regard to the number of casualties, severity of injuries and location of the incident.
   c. When resources are not immediately available for response within San Bernardino County, the County Communications Center will request appropriate medical mutual aid from the closest contiguous county.
   d. If resource requests are received by the County Communications Center that may seriously deplete the EMS System resources, the EMS Agency, Health Officer or duty officer will be immediately notified to assist in coordination of resources.
   e. All mutual aid resource requests which are on a stand-by basis will be coordinated by the EMS agency in conjunction with the Communications Center.
2. Identification of Ambulance and Patient Load:
   Obtain the ambulance identification and the patient load from the transportation group supervisor or Incident Commander (IC) as the ambulances are loaded.
3. Hospital Destination
   After receiving the patient load information, determine current “immediate” and “delayed” emergency room capability for affected hospitals. This information will be passed on to the Incident Commander or the Medical Unit Leader/Transportation Unit Leader to direct departing ambulances to the appropriate receiving hospital. This routing information shall be coordinated with but not determined by the Communications Center.

4. Returning to Normal Operating Mode:
   When the transportation group supervisor or Incident Commander has determined that all casualties have been accounted for, advise all affected hospitals to return to the normal operating mode. The San Bernardino County Communications Centers shall also notify the Health Officer.

Cost Reimbursement

All response for ambulance mutual aid within the County of San Bernardino between county providers will be provided at no cost to the requesting party.

Reimbursement for "stand-by" will be handled as follows:

1. Non-dedicated stand-by
   There will be no cost to the requesting agency for "stand-by" ambulances when it is understood that the "stand-by" ambulance may leave the staging area if dispatched to a 911 call.
2. Dedicated stand-by
   a. An ambulance that is requested to stage at an incident and remain dedicated to that area for less than two hours will be provided at no cost to the requesting agency.
   b. If the dedicated ambulance unit is on-scene for more than two hours, the ambulance provider agency may charge up to $100/hour for each ALS *(Type I***)** unit and $80 /hour for each BLS *(Type II*) unit.
   c. In the event that an ambulance provider enters into a contract to provide "stand-by" services when requested, the reimbursement rate will be delineated in the contract.

ESOPHAGEAL TRACHEAL AIRWAY DEVICE (ETAD)
SERVICE PROVIDER REQUIREMENTS

AUTHORITY
California Code of Regulations Title 22, Division 9, Chapter 2. Section 100064

PURPOSE
To establish a standard mechanism for approval and designation of an EMT-I ETAD service provider

PROCEDURE

Provider agencies seeking approval shall submit the following to ICEMA prior to beginning service:

1. Description of the geographic area served by the provider agency including:
   a. Population
   b. Rural vs. urban or combination
   c. Projected coverage
   d. Average ETA of a transport provider
   e. Average ETA to the nearest acute care receiving facility
2. A statement agreeing to comply with all of ICEMA protocols and procedures related to the program
3. Identify the individual responsible for managing the program (program coordinator)
4. Identify the primary instructor with qualifications and training program to be used
5. Policies and procedures to ensure orientation and continued competency of accredited personnel.
6. Identify the CQI program including the methods used to review
7. Anticipated number of personnel to be trained

RECORD KEEPING AND REPORTING REQUIREMENTS

1. A patient care report form (O1A) shall be completed for each patient on whom the ETAD is used and utilized by the provider for quality assurance purposes.
2. Advanced skills form completed and sent to ICEMA BLS coordinator.
3. The ETAD service provider is responsible for assuring the continued competency of the EMT-I skill level, either through skills testing or appropriate usage of the device.
4. All relevant records related to monitoring of the program shall be available for review by ICEMA
5. Required statistical information for each patient that the ETAD was utilized shall be reported each March 1 for the previous calendar year to ICEMA including:
   a. Age
   b. Gender
   c. Indications for use
   d. Outcome
   e. Number of attempts
   f. Number of personnel employed by your department that are trained in the use of the device.

REPULSE OXIMETRY (PULSE OX)
SERVICE PROVIDER REQUIREMENTS

AUTHORITY

Health and Safety Code, Division 2.5, Sections 1797.196, California Code of Regulations Title 22 Division 9., Chapter 2 Emergency Medical Technician I.

PURPOSE

To establish a standard mechanism for approval and designation of an EMT-I Pulse Oximetry service provider.

PROCEDURE

Provider agencies seeking approval shall submit the following to ICEMA prior to beginning service:

1. A statement agreeing to comply with all of ICEMA protocols and procedures related to the program
2. Identify the individual responsible for managing the program (program coordinator)
3. Policies and procedures to ensure orientation and continued competency of designated personnel.
4. Identify the CQI program including the methods used to review
5. Anticipated number of personnel to be trained.
6. Agree to follow approved ICEMA curriculum or submit curriculum for review and approval by ICEMA.

RECORD KEEPING

Pulse Oximetry readings shall be documented on Patent Care Record (O1A)

AUTOMATIC EXTERNAL DEFIBRILLATOR (AED) SERVICE PROVIDER REQUIREMENTS

AUTHORITY
Health and Safety Code, Division 2.5, Sections 1797.196, California Code of Regulations Title 22 Division 9., Chapter 2 Emergency Medical Technician I.

PURPOSE
To establish a standard mechanism for approval and designation of EMT AED Service Providers in the ICEMA region.

POLICY
ICEMA shall approve all EMT AED service providers prior to beginning service. Approval may be revoked or suspended for failure to comply with requirements of this policy or Title 22.

BLS AED SERVICE PROVIDER APPROVAL

Provider agencies that are seeking approval to implement AED services shall submit the following to ICEMA for review and approval prior to beginning service:

1. Description of the area served by the provider agency.
2. The model name of the AED(s) to be utilized.
3. Identify the individual responsible for managing the AED program.
4. Identify the primary instructor with qualifications and the training program to be used.
5. Policies and procedures to ensure orientation of AED authorized personnel.
6. Procedures for maintenance of the AED.
7. Policies and procedures to collect maintain and evaluate patient care records. Attached AED Event Summary Worksheet may be utilized.

RECORD KEEPING AND REPORTING REQUIREMENTS

The following data will be collected and reported to ICEMA by March 1 for the previous calendar year.

1. The total number of patients defibrillated who were discharged from the hospital alive.
2. The number of patients with sudden cardiac arrest receiving CPR prior to arrival of emergency medical care.
3. The total number of patients on whom defibrillatory shocks were administered, witnessed (seen or heard) and not witnessed.
4. The number of these persons who suffered a witnessed cardiac arrest whose initial monitored rhythm was ventricular tachycardia or ventricular fibrillation.
5. Maintain a listing of all AED personnel and provide upon request to ICEMA.

PUBLIC SAFETY AUTOMATIC EXTERNAL DEFIBRILLATOR (AED) SERVICE PROVIDER REQUIREMENTS

PURPOSE

To establish a standard mechanism for designation and approval of Public Safety AED Service Providers in the ICEMA region.

AUTHORITY

Health and Safety Code, Division 2.5, Sections 1797.196, California Code of Regulations Title 22 Division 9, Chapter 1.5 First Aid Standards for Public Safety Personnel.

POLICY

AED Public Safety service providers shall be approved by ICEMA prior to beginning service. Approval may be revoked or suspended for failure to comply with requirements of this policy or Title 22.

PUBLIC SAFETY AED SERVICE PROVIDER APPROVAL

Provider agencies that are seeking approval to implement AED services shall submit the following to ICEMA for review and approval:

1. Description of the area served by the provider agency.
2. The model name of the AED(s) to be utilized.
3. Identify the individual responsible for managing the AED program.
4. Identify the primary instructor with qualifications.
5. Identify the training program to be used.
6. Policies and procedures to ensure orientation and continued competency of all AED trained personnel.
7. Procedures for maintenance of the AED.
8. Policies and procedures to collect maintain and evaluate patient care records. Attached AED Event Summary Worksheet may be utilized.
9. Identify the Medical Director.

RECORD KEEPING AND REPORTING REQUIREMENTS

The following data will be collected and reported to ICEMA annually by March 1 for the previous calendar year.

1. The total number of patients defibrillated who were discharged from the hospital alive
2. The number of patients with sudden cardiac arrest receiving CPR prior to arrival of emergency medical care.
3. The total number of patients on whom defibrillatory shocks were administered, witnessed (seen or heard) and not witnessed.
4. The number of these persons who suffered a witnessed cardiac arrest whose initial monitored rhythm was ventricular tachycardia or ventricular fibrillation.
5. A listing of all public safety AED authorized personnel

EMERGENCY MEDICAL DISPATCHER CERTIFICATION

PURPOSE

To define requirements for initial certification of eligible individuals as an Emergency Medical Dispatcher (EMD) at an approved EMD Dispatch Center in the Inland Counties Region.

POLICY

The applicant shall be issued an EMD certificate upon successful completion and verification of all of the requirements.

The expiration date of an EMD certificate shall be two (2) years from the date of successful completion of the EMD certifying examination.

The certification fee paid to ICEMA is nonrefundable.

ELIGIBILITY

In order to be eligible to become certified as an EMD, an individual must:

1. Be eighteen (18) years of age or older.
2. Document successful completion of an ICEMA approved EMD Training Program within the last six (6) months (a list of approved programs is available through ICEMA).
3. Have a current American Heart Association BCLS level B or an American Red Cross Community CPR card.

PROCEDURE

1. An individual applying for certification as an EMD within the ICEMA region shall:
    a. Submit a completed ICEMA application form within six (6) months of being issued a course completion record. Incomplete applications will not be accepted or acknowledged and will be returned to the individual.
    b. Complete a statement that the individual is not precluded for certification for reasons defined in Section 1798.200 of the Health and Safety Code.
    c. Submit a 1" x 1¼" drivers' license-type photograph, no hats or dark glasses accepted. A photo may be taken at ICEMA at no charge. If the photo is submitted by mail, it will be necessary that it be accompanied by a photocopy of the applicant's driver's license for verification purposes.
    d. Pay the established fee at time of application (Cashier's check, money order, cash or agency check only; no personal checks will be accepted).
    e. Submit a photocopy of the individual's current BCLS/CPR card as specified above.
2. After verification of eligibility, the applicant shall take the ICEMA written certification exam. The individual must score at least eighty percent (80%) in order to successfully complete the written examination. The individual will be allowed to take the certification examination a second time and must score at least eighty percent (80%) to be successful. Failure to successfully complete the written certification exam on the second attempt will constitute failure of the entire process, and the individual must take and successfully complete an approved EMD basic course in order to re-enter the certification process.

FIRST RESPONDER CERTIFICATION CRITERIA

PURPOSE

To define requirements for the certification of eligible individuals, who voluntarily request certification, by the Medical Director of the local EMS Agency as a First Responder.

ELIGIBILITY

In order to be eligible to apply for certification as a First Responder, an individual at the time of application must:

1. Be a minimum of eighteen (18) years of age
2. Provide documentation of successful completion of an approved course within six (6) months prior to application for certification and possess a course completion record from same.
3. Pass by pre-established standards a competency based written and skills examination approved by this local EMS Agency.

PROCEDURE

An individual applying for certification as a First Responder within this region shall:

1. Apply for certification within six (6) months of successful passage of the written and skills examination
2. Submit a completed application with the appropriate fee (cash, money order or provider checks only). Fees paid for certification are not refundable or transferable
3. Submit a current 1" x 1¼" driver's license style photograph. If the photo is submitted by mail, it will be necessary that it be accompanied by a photocopy of the applicant's driver's license for verification purposes.
4. Submit a signed copy (front and back) of the individual's current American Heart Association BCLS Level C or American Red Cross Professional Rescuer CPR card

The expiration date shall be two (2) years from the date of successful passage of the First Responder certifying examination.

FIRST RESPONDER RECERTIFICATION CRITERIA

PURPOSE

To define requirements for the recertification of eligible individuals, who voluntarily request certification, by the Medical Director of the local EMS Agency as a First Responder.

ELIGIBILITY

In order to be eligible to apply for recertification as a First Responder, an individual at the time of application must:

1. Be a minimum of eighteen (18) years of age
2. Possess a valid First Responder certification in the State of California which is issued by an EMS certifying authority and has not expired for more than twelve (12) months.
3. Provide documentation of successful completion of an approved refresher course within six (6) months prior to application for recertification and possess a course completion record from same.
4. Pass by pre-established standards a competency based written and skills examination approved by this local EMS Agency.

PROCEDURE

An individual applying for recertification as a First Responder within this region shall:

1. Apply for recertification within six (6) months of successful passage of the written and skills examination
2. Meet all recertification requirements within six (6) months prior to the expiration date to retain the expiration date of the current certificate; otherwise, the expiration date shall be two (2) years from the date of successful passage of the First Responder recertifying examination
3. Submit a completed application with the appropriate fee (cash, money order or provider checks only). Fees paid for certification are not refundable or transferable
4. Submit a photocopy of the front and back of the certificate which qualifies the individual to apply for recertification as a First Responder
5. Submit a current 1" x 1¼" driver's license style photograph. If the photo is submitted by mail, it will be necessary that it be accompanied by a photocopy of the applicant's driver's license for verification purposes . Submit a signed copy (front and back) of the individual's current American Heart Association BCLS Level C or American Red Cross Professional Rescuer CPR card

EMT-I CERTIFICATION REQUIREMENTS

AUTHORITY
California Code of Regulations, Title 22, Division 9, Chapter 2.

PURPOSE
To define requirements for the certification of an eligible individual as an Emergency Medical Technician-I (EMT-I) in the Counties of San Bernardino, Inyo and Mono.

ELIGIBILITY

Initial Certification

1. Possess a course completion record or other documented proof of successful completion of an approved EMT-I training program or have documentation of successful completion of an approved out-out-state EMT-I training course within the last two years which meets the requirements of Title 22, Division 9, Chapter 2 of the California Code of Regulations.
2. Apply for certification within two (2) years of the course completion date.
3. Prior to January 1, 2006, pass by pre-established standards, the ICEMA approved competency-based written and skills certification examination
4. After January 1, 2006, pass by pre-established standards, the written and skills examination approved by the California EMS Authority.
5. Be eighteen (18) years of age or older.
6. Comply with other requirements as may be set forth herein.

EMT-I Certification with a Lapsed California EMT-II Certification or Paramedic License

1. Lapse of less than six months;
   a. Submit a completed skills competency verification form, EMSA-SCV (07/03) ***and***
   b. Obtain at least twenty-four hours of continuing education hours (CEH) from an approved continuing education provider per Protocol Reference #14011 Continuing Education Provider Policy ***or***
   c. Successfully complete a twenty-four hour refresher course from an approved EMT-I training program
2. Lapse of six months or more, but less than twelve months:
   a. Comply with B.1 a through c above ***and***
   b. Complete an additional twelve hours of continuing education for a total of 36 hours of training.
3. Lapse of twelve months or more, but less than 24 months:
   a. Comply with B.1 a through c above ***and***
   b. Complete an additional twenty-four hours of continuing education for a total of 48 hours ***and***
   c. Pass the written and skills certification exam approved as approved by the California EMS Authority.
4. Lapse of twenty-four months or more:
   a. Complete an entire EMT-I course ***and***
   b. Comply with the initial certification requirements set forth in this protocol.

Other Qualifying Categories

1. An individual currently licensed in California as a Paramedic or currently certified in California as an EMT-II is deemed to be certified as an EMT-I with no further testing required **EXCEPT** when the paramedic license or EMT-II certification is under suspension. A Paramedic whose license is under suspension shall apply to ICEMA for EMT-I certification.
2. An individual who meets one of the following criteria shall be eligible for certification upon fulfilling the requirements established by ICEMA
    a. Possess a current and valid National Registry EMT-I Basic certificate, ***or***
    b. Possess a current and valid out-of-state or National Registry EMT-Intermediate or EMT-P certificate ***or***
    c. Possess a current and valid out-of-state EMT-I certificate

PROCEDURE

An individual applying for certification as an EMT-I within the ICEMA region shall:

1. Submit the appropriate ICEMA application with
    a. Certification fee as set by ICEMA: Only cash, money order, cashier's check, or institutional check will be accepted. Fees are non-refundable and non-transferable.
    b. Copy of front and back of current signed BLS/CPR card.
2. Provide a photo either taken at ICEMA when application is submitted or applicant may submit a driver's license size (no tinted glasses or hats) with his/her application.
3. Complete a statement that the individual is not precluded from certification for reasons defined in Section 1798.200 of the Health and Safety Code.
4. Provide documentation of requirements for eligibility.

POLICY

1. The effective date of certification shall be the date the individual satisfactorily completes all certification requirements and has applied for certification.
2. The certification expiration date will be the final day of the final month of the two (2) year period.
3. The expiration date shall be the same expiration date as stated on the out-of-state or National Registry certification for an individual who possesses a current and valid out-of-state EMT-I, EMT-Intermediate or Paramedic certification or a current and valid National Registry EMT-Basic, EMT-Intermediate or Paramedic certification.
4. The EMT-I expiration date for a Paramedic currently licensed shall be the same date as the current Paramedic license.

EMT-I CERTIFICATION CHALLENGE REQUIREMENTS

AUTHORITY
California Administrative Code, Title 22, Division 9, Article 3, Section 100078.

PURPOSE
To define the challenge requirements for certification as an Emergency Medical Technician-I (EMT-I).

ELIGIBILITY

An individual may obtain an EMT-I course completion by successfully passing an ICEMA approved course challenge examination if she/he meets one of the following eligibility requirements:

1. Currently licensed physician, registered nurse, physician assistant, vocational nurse, or currently licensed paramedic. An individual currently licensed in California as a paramedic or currently certified as an EMT-II is deemed to be certified as an EMT-I with no further testing required.
2. Provide documented evidence of having successfully completed an emergency medical services training program of the Armed Forces, including the Coast Guard, of the United States within the preceding two (2) years which meets the Department of Transportation course guidelines. Upon review of documentation, the EMT-I certifying authority may also allow an individual to challenge if the individual was active in the last two (2) years in a prehospital emergency medical classification of the Armed Services, including the Coast Guard of the United States, which does not have formal recertification requirements. These individuals may be required to take a refresher course or obtain continuing education hours according to the "EMT-I Continuing Education Requirements #15207" as a condition of certification.

POLICY

1. The approved EMT-I challenge examination shall consist of a competency-based written and skills examination to test the knowledge of the topics and skills as prescribed in the EMT-I regulations.
2. An eligible person shall be permitted to take the EMT-I challenge exam one time.
3. An eligible person who fails to achieve a passing score on the EMT-I challenge exam shall successfully complete an EMT-I course to receive an EMT-I course completion.
4. The effective date of certification shall be the date the individual satisfactorily completes all certification requirements and applies for certification.
5. The certification expiration date will be the final day of the final month of the two (2) year period.

PROCEDURE

An individual applying for certification as an EMT-I within the ICEMA region shall:

1. Submit the appropriate ICEMA application with
   a. Certification fee as established by ICEMA: only cash, money order, cashier's check, or institutional check will be accepted. Fees are non-refundable and non-transferable.
   b. Copy of front and back of current signed BLS/CPR card.
2. Provide a photo either taken at ICEMA when application is submitted or applicant may submit a driver's license size (no tinted glasses or hats) with their application.

3. Complete a statement that the individual is not precluded from certification for reasons defined in Section 1798.200 of the Health and Safety Code.
4. Provide documentation of requirements for eligibility.

MAINTAINING EMT-I CERTIFICATION

AUTHORITY
California Administrative Code, Title 22, Division 9, Article 5, Section 100080

PURPOSE
To define the requirements to maintain certification as an Emergency Medical Technician-I (EMT-I) in the Counties of San Bernardino, Inyo, and Mono.

ELIGIBILITY

To maintain certification as an Emergency Medical Technician-I (EMT-I), an individual at the time of application shall:

1. Possess a current California EMT-I certification issued in California.
2. Obtain at least twenty-four hours of continuing education hours (CEH) from an approved continuing education provider in accordance with the provisions contained in Protocol #14011 or successfully complete a twenty-four hour refresher course from an approved EMT-I training program.
3. Submit a completed skills competency verification form, EMSA-SCV (07/03)

CURRENTLY CERTIFIED

1. If requirements are met within six (6) months prior to the expiration date, the effective date of certification shall be the expiration date of the current certificate.
2. If requirements are met more than six (6) months prior to the expiration date, the effective date of certification will be the date the individual satisfactorily completes all certification requirements and has applied for certification.

LAPSE IN CERTIFICATION

1. Lapse of less than six (6) months: Comply with the requirements contained in the eligibility section above.
2. Lapse of six months or more, but less than twelve months: Comply with requirements contained in the eligibility section above **and** complete an additional twelve (12) hours' continuing education for a total of 36 hours of training.
3. Lapse of twelve months or more, but less than 24 months: Comply with the eligibility requirements of this protocol **and** complete an additional twenty-four hours'continuing education for a total of 48 hours of training **and** pass the written and skills certification exam as specified in Protocol #15201.
4. Lapse of greater than twenty-four months: Complete an entire EMT-I course and comply with the requirements of Protocol #15201.

PROCEDURE

An individual applying for certification, as an EMT-I within the ICEMA region shall:

1. Submit the appropriate ICEMA application with:
   a. Certification fee as established by ICEMA: Only cash, money order, cashier's check, or institutional check will be accepted. Fees are non-refundable and non-transferable;
   b. Copy of front and back of current signed BLS/CPR card.

2. Provide a photo either taken at ICEMA when application is submitted or applicant may submit a driver's license size (no tinted glasses or hats) with his/her application.
3. Complete a statement that the individual is not precluded from certification for reasons defined in Section 1798.200 of the Health and Safety Code.
4. Provide documentation of completion of continuing education requirements in accordance with Protocol Reference #15207 and #14011
5. Submit a completed skills competency verification form, EMSA-SCV (7/03).

The effective date of certification shall be the date the individual satisfactorily completes all certification requirements and has applied for certification. The certification expiration date shall be the final day of the final month of the two (2) year period.

State of California
EMT-I Skills Competency Verification Form
EMSA – SCV (07/03)

See back of form for instructions for completion

1a. Name as shown on EMT-I Certificate	1b. Certificate Number	1c. Signature
1d. Certifying Authority	1e. Date	I certify, under the penalty of perjury, that the information contained on this form is accurate.

Skill	Verification of Competency	
1. Patient examination, trauma patient;	Affiliation	Date
Signature of Person Verifying Competency	Print Name	Certification / License Number
2. Patient examination, medical patient	Affiliation	Date
Signature of Person Verifying Competency	Print Name	Certification / License Number
3. Airway emergencies	Affiliation	Date
Signature of Person Verifying Competency	Print Name	Certification / License Number
4. Breathing emergencies	Affiliation	Date
Signature of Person Verifying Competency	Print Name	Certification / License Number
5. Automated external defibrillation	Affiliation	Date
Signature of Person Verifying Competency	Print Name	Certification / License Number
6. Circulation emergencies	Affiliation	Date
Signature of Person Verifying Competency	Print Name	Certification / License Number
7. Neurological emergencies	Affiliation	Date
Signature of Person Verifying Competency	Print Name	Certification / License Number
8. Soft tissue injury	Affiliation	Date
Signature of Person Verifying Competency	Print Name	Certification / License Number
9. Musculoskeletal injury	Affiliation	Date
Signature of Person Verifying Competency	Print Name	Certification / License Number
10. Obstetrical emergencies	Affiliation	Date
Signature of Person Verifying Competency	Print Name	Certification / License Number

INSTRUCTIONS FOR COMPLETION OF EMT-I SKILLS COMPETENCY VERIFICATION FORM

A completed EMT-I Skills Verification Form is required to accompany an EMT-I recertification application for those individuals who are either maintaining EMT-I certification without a lapse or who are renewing EMT-I certification with a lapse in certification less than one year.

1a. Name of Certificate Holder
Provide the complete name, last name first, of the EMT-I certificate holder who is demonstrating skills competency.

1b. Certificate Number
Provide the EMT-I certification number from the current or lapsed EMT-I certificate of the EMT-I certificate holder who is demonstrating competency.

1c. Signature
The EMT-I certificate holder who is demonstrating competency must sign. By signing this section, the EMT-I is verifying that the information contained on this form is accurate and that the EMT-I certificate holder has demonstrated competency in the listed skills to a qualified individual.

1d. Certifying Authority
Identify the EMS Agency through whom the EMT-I is seeking certification.

Verification of Competency

1. Affiliation - Provide the name of the training program or EMS service provider with whom the qualified individual is affiliated.

2. Once competency has been demonstrated by direct observation of an actual or simulated patient contact, i.e. skills station, the individual verifying competency shall sign the EMT-I Skills Competency Verification Form (EMSA-SCV 07/03) for that skill.

3. Qualified individuals who verify skills competency shall be currently licensed or certified as: An EMT-I, EMT-II, Paramedic, Registered Nurse, Physician Assistant, or Physician **and** shall be either a qualified instructor designated by an EMS approved training program (EMT-I training program, paramedic training program or continuing education training program) or by a qualified individual designated by an EMS service provider. EMS service providers include, but are not be limited to, public safety agencies, private ambulance providers, and other EMS providers.

4. Certification or License Number – Provide the certification or license number for the individual verifying competency.

5. Date- Enter the date that the individual demonstrates competency in each skill.

6. Print Name – Print the name of the individual verifying competency in the skill.

Verification of skills competency shall be valid to apply for EMT-I recertification for a maximum of two years from the date of verification.

EMT-I CONTINUING EDUCATION REQUIREMENTS

AUTHORITY
California Administrative Code, Title 22, Division 9, Article 5, Section 100080.

PURPOSE
To define requirements for continuing education for certified Emergency Medical Technicians-I (EMT-Is) in the Counties of San Bernardino, Inyo and Mono.

POLICY
To maintain certification, an EMT-I shall:

1. Obtain at least twenty-four hours' continuing education hours (CEH) from an approved continuing education provider ***or***
2. Successfully complete a twenty-four hour refresher course from an approved EMT-I training program.

CONTINUING EDUCATION

1. Continuing education hours may be earned in the following manner:
   a. Any of the topics contained in the respective National Standard Curricula for training EMS personnel;
   b. Classroom, didactic and/or skills laboratory with direct instructor interaction;
   c. Organized field care audits of patient care records;
   d. Courses offered by accredited universities and colleges, including junior and community colleges;
   e. Structured clinical experience, with instructional objectives, to review or expand the clinical expertise of the individual;
   f. Media based and/or serial productions (e.g. films, videos, audiotape programs, magazine articles offered for CE credit, home study, computer simulations or interactive computer modules);
   g. Precepting EMS students or EMS personnel as a hospital clinical preceptor, as assigned by the EMS training program, EMS service provider, hospital or base hospital;
   h. Advanced topics in subject matter outside the scope of practice of the certified or licensed EMS personnel but directly relevant to emergency medical care;
   i. An instructor for a CE course, class or activity will earn credit equal to the same number of CE hours applied to the course, class or activity.
2. At least fifty percent of the required CE hours must be in an instructor-based format, where an instructor is readily available to the student to answer questions, provide feedback, (e.g., on-line CE course where an instructor is available to the student). The CE provider approving authority shall determine whether a CE course, class or activity is instructor based.
3. Credit may be given for taking the same CE course, class or activity no more than two times during a single certification cycle.
4. An individual shall provide proof of approved continuing education hours obtained to the local EMS agency upon request and at the time of application.
5. An individual who is currently licensed in California as a Paramedic or certified as an EMT-II or who has been certified within (6) six months of the date of application may be given credit for continuing education hours earned as a Paramedic or EMT-II to satisfy the continuing education requirement for EMT-I recertification
6. Continuing education may be obtained at any time throughout the current certification period.

REQUIREMENTS FOR EMT-P ACCREDITATION

PURPOSE

To define the accreditation requirements for an eligible individual to practice as an Emergency Medical Technician-Paramedic (EMT-P) within the counties of Inyo, Mono and San Bernardino.

AUTHORITY

Title 22, Division 9, Chapter 4, Section 100164 of the California Health and Safety Code.

PROCEDURE

Initial EMT-P Accreditation

1. Possess a current California EMT-P license
2. Submit the appropriate ICEMA application with:
   a. Fee as set by ICEMA. The fee is not refundable or transferable.
   b. Verification of employment or intent to employ as an EMT-P by an authorized ALS provider agency or by an EMS provider agency that has formally requested ALS authorization in the ICEMA region.
   c. Copy of front and back of current signed BLS/CPR and ACLS cards.
   d. Copy of course completion certificate.
3. Photo taken at ICEMA when application is submitted. Applicant may submit a driver's license size photo (no tinted glasses or hats) with their application.
4. A provisional card will be issued upon receipt of items #1 through #3. The provisional EMT-P may function using the approved State Basic Scope of Practice while working with a partner who is fully accredited as an EMT-P within the local EMS region for thirty (30) calendar days from receipt of completed application. The ICEMA Medical Director may extend this provisional status for just cause.
5. If the accreditation requirements are not completed within thirty (30) days, the applicant must complete a new application and pay a new fee to begin another thirty (30) day period. An applicant may only apply for initial accreditation a maximum of three (3) times per calendar year.
6. Successfully complete an orientation (not to exceed eight (8) classroom hours) of local protocols and policies given by an ICEMA approved EMT-P orientation/skills instructor, and document training in all ICEMA undefined scope of practice areas. The ICEMA Medical Director may waive this requirement for EMT-P graduates from an approved EMT-P training institution in this region.
7. Successfully pass the local accreditation written examination with a minimum score of eighty percent (80%) and attend the skills testing in ICEMA undefined scope of practice. The EMS Medical Director may waive skills testing for EMT-P graduates from an approved EMT-P training institution in this region.
   a. A candidate who fails to pass the ICEMA written exam on the first attempt will have to pay the ICEMA approved fee and re-take the exam with a score of 85%.
   b. A candidate who fails to pass the ICEMA written exam on the second attempt will have to pay the ICEMA approved fee, and provide documentation of eight (8) hours of remedial training in relation to ICEMA protocols, policies / procedures given by their EMS/QI Coordinator and pass the ICEMA exam with a score of 85%.
   c. If the candidate fails to pass the ICEMA exam on the third attempt, the ICEMA Medical Director will review the candidate's application to determine additional training requirements
8. Successfully complete a supervised field evaluation to consist of no less than five (5) but no more than ten (10) ALS responses. The ICEMA Medical Director may waive this requirement for EMT-P graduates from an approved EMT-P training institution in this region. who have met **all** of the following conditions:

a. Course completion was within six (6) months of the date of application for accreditation.
b. Field internship was obtained within the ICEMA region with an ICEMA approved EMT-P preceptor.
c. Complete and sign the waiver documenting items (a) and (b). No other form will be accepted.

9. The Medical Director shall evaluate any candidate who fails to successfully complete the field evaluation and recommend further evaluation or training as required. Failure to complete the supervised field evaluation may constitute failure of the entire process.
10. The local EMS agency will notify individuals applying for accreditation of the decision to accredit within thirty (30) days of receipt of completed application.

EMT-P Continuous Accreditation

1. Possess a renewed California EMT-P license and current ICEMA accreditation If ICEMA accreditation has lapsed for more than one (1) year, the individual must comply with the Initial Accreditation Procedure.
2. Photo taken at ICEMA when renewal form is submitted. A driver's license size photo (no tinted glasses or hats) may be submitted with the renewal form
3. Submit the ICEMA Continuous Accreditation Renewal Form with:
   a. Verification of employment or intent to employ as an EMT-P by an authorized ALS provider agency or by an EMS provider agency that has formally requested ALS authorization by ICEMA
   b. Copy of front and back of current signed BLS/CPR and ACLS cards.
   c. Documentation of two (2) ICEMA approved skills Days. One taken during each year of accreditation.
   d. Documentation of six (6) hours of field care audits obtained within the ICEMA region.
   e. Documentation of two (2) different ICEMA Protocol Update Curriculum classes. (NOTE: This requirement will remain in effect until December 31, 2006. After that date the Annual Curriculum Class will replace the PUC.)
4. Individuals without documentation of b, c, d, and e above must provide documentation to ICEMA of completion of these requirements within 30 days of submission of the Continuous Accreditation Renewal Form If documentation has not been received at ICEMA within the specified time the ICEMA Medical Director will determine additional requirements.
5. Individuals without documentation of two (2) different PUC classes must: (NOTE: This requirement will remain in effect until December 31, 2006. After that date the Annual Curriculum Class will replace the PUC.)
   a. Pay fee as set by ICEMA and successfully pass the ICEMA Accreditation Examination with a score of eighty percent (80%).
   b. A candidate who fails to pass the ICEMA written exam on the first attempt will have to pay the ICEMA approved fee and re-take the exam with a score of 85%.
   An individual who fails to pass the ICEMA Accreditation Examination on the second attempt will have to pay the ICEMA approved fee, and provide documentation of eight (8) hours of remedial training in relation to ICEMA protocols, policies / procedures given by their EMS/QI Coordinator and pass the ICEMA exam with a score of 85%.
   d. If the individual fails to pass the ICEMA Accreditation Examination on the third attempt, the ICEMA Medical Director will determine additional training requirements.

APPROVED:

		2.28.06	
		ICEMA Medical Director	Date
	MAR 0 8 2006		3/16/06
San Bernardino Co. Health Officer	Date	Inyo Co. Health Officer	Date
	3/21/06		3/16/06
Mono Co. Health Officer	Date	ICEMA Executive Director	Date

REQUIREMENTS FOR MICN CERTIFICATION

PURPOSE

To define the requirements for Mobile Intensive Care Nurse (MICN) certification within the ICEMA Region

PROCEDURE

Initial MICN Certification

1. Possess a current California RN License
2. Successfully complete the ICEMA approved MICN course with a passing score of eighty percent (80%), and within six (6) months of course completion, submit the appropriate ICEMA application with:
   a. Fee as set by ICEMA
   b. Written verification of employment at a designated Base Hospital within the ICEMA Region
   c. Copy of front and back of a current, signed ACLS Card
   d. Copy of front and back of current California RN License
3. Photo taken at ICEMA when application is submitted. Applicant may submit a driver's license size photo (no tinted glasses or hats) with their application.
4. Upon completion of 1-3 above, the applicant will be scheduled to take the ICEMA exam.
5. Upon passing the ICEMA written exam with a score of eighty percent (80%), a provisional MICN card will be issued.
   a. A candidate who fails to pass the ICEMA written exam on the first attempt will have to pay the ICEMA approved fee and re-take the exam with a score of 85%.
   b. A candidate who fails to pass the ICEMA written exam on the second attempt will have to pay the ICEMA approved fee, and provide documentation of eight (8) hours of remedial training given by their PLN/Medical Director relating to ICEMA protocols, policies/procedures given by their PLN and pass the ICEMA exam with a score of 85%.
   c. If the candidate fails to pass the ICEMA exam on the third attempt, the ICEMA Medical Director will review the candidate's application to determine additional training requirements.
6. A provisional MICN may function under the direct supervision of either the Base Hospital MD, PLN, or ICEMA approved designee for a maximum of six (6) months. The supervising individual must sign all MICN call forms. This timeframe may be extended upon receipt of a request in writing from either the candidate or PLN outlining any extenuating circumstances.
7. The PLN will choose three (3) tapes for review (one trauma, one medical and one other) and submit them to their partnered Base Hospital PLN for review.
8. When three (3) tapes meet ICEMA criteria, a MICN card will be issued with the same expiration date as the candidates RN license.
9. Failure to complete the entire process within one (1) year of application date constitutes failure of the entire process. The timeframe may be extended by the ICEMA Medical Director upon receipt of a request in writing from either the candidate or PLN outlining any extenuating circumstances.

Continuous MICN Certification

1. Possess a current California RN License and current ICEMA MICN certification.
2. Submit the appropriate completed ICEMA application with:
   a. Written verification of employment at a designated Base Hospital within the ICEMA Region
   b. Copy of front and back of a current, signed ACLS Card
   c. Copy of front and back of current California RN License

d. Documentation of eight (8) hours of field time
e. Documentation of one (1) ICEMA approved Skills Day
f. Documentation of six (6) hours of field care audits obtained within the ICEMA region
g. Documentation of two (2) different ICEMA Protocol Update Curriculum classes (NOTE: This requirement will remain in effect until December 31, 2006. After that date the Annual Curriculum Class will replace the PUC.)
h. Continuous certification applicants not meeting this requirement must pay the ICEMA approved fee and successfully pass the ICEMA written examination with a score of 80%.

3. Current photo (within last 6 months) on file at ICEMA. Applicant may submit a driver's license size photo (no tinted glasses or hats) with their application.
4. If the certification has lapsed for more than one (1) year, the applicant must comply with the above Initial Certification Procedure.

Inactive MICN Certification

1. Maintain a current California RN License
2. Submit the appropriate completed ICEMA application with all of the following documentation every two (2) years of inactivation.
   a. Copy of front and back of a current, signed ACLS Card.
   b. Copy of front and back of current California RN License
   c. Documentation of one (1) ICEMA approved Skills Day taken during each year of inactivation.
   d. Documentation of four (4) hours of field care audits obtained within the ICEMA region for every year of inactivation.
   e. Documentation of one (1) ICEMA Protocol Update Curriculum classes for each year of inactivation (This requirement will remain in effect until December 31, 2006. After that date the Annual Curriculum Class will replace the PUC.)

Return to Active MICN Status

1. Submit the appropriate ICEMA application with documentation of all inactive MICN Certification requirements and written verification of employment at a designated Base Hospital within the ICEMA Region.
2. Upon receipt of above documentation, and photo, the candidate will be scheduled for the ICEMA exam.
3. Upon passing the ICEMA Written Exam with a score of 80%, a provisional MICN card will be issued.
   a. A candidate who fails to pass the ICEMA written exam on the first attempt will have to pay the ICEMA approved fee and re-take the exam with a score of 85%.
   b. A candidate who fails to pass the ICEMA written exam on the second attempt will have to pay the ICEMA approved fee, and provide documentation of eight (8) hours of remedial training given by their PLN or Medical Director relating to ICEMA protocols, policies/procedures and pass the ICEMA exam with a score of 85%.
   c. If the candidate fails to pass the ICEMA exam on the third attempt, the applicant will have to take and pass the ICEMA approved MICN course.
4. A provisional MICN may function under the direct supervision of either the Base Hospital MD, PLN, or ICEMA approved designee for a maximum of six (6) months. The supervising individual must sign all MICN call forms.
5. After obtaining a provisional MICN, the individual must complete eight (8) hours of field time
6. The PLN will choose three (3) tapes for review (one trauma, one medical and one other) and submit them to their partnered Base Hospital PLN for review.
7. When three (3) tapes meet ICEMA criteria, a MICN card will be issued with the same expiration date as the candidates RN license.

8. Failure to complete the entire process within one (1) year of application date constitutes failure of the entire process. The timeframe may be extended by the ICEMA Medical Director upon receipt of a request in writing from either the candidate or PLN outlining any extenuating circumstances.

Certification by Challenge Examination

1. Possess a current California RN License.
2. Meet one (1) of the following eligibility requirements:
   a. MICN in another county within previous twelve (12) months.
   b. MICN in ICEMA Region, but has let certification expire within the previous forty-eight (48) months, and has not fulfilled requirements for inactive MICN status.
3. Submit the appropriate ICEMA application with:
   a. Fee as set by ICEMA.
   b. Written verification of employment at a designated Base Hospital within the ICEMA Region.
   c. Copy of front and back of a current, signed ACLS Card.
   d. Copy of front and back of current California RN License.
4. Photo taken at ICEMA when application is submitted. Applicant may submit a driver's license size photo (no tinted glasses or hats) with their application.
5. Upon completion of 1-4 above, the applicant will be scheduled to take the ICEMA written exam.
6. Upon passing the ICEMA written exam with a minimum score of 80%, a provisional MICN card will be issued.
   a. A candidate who fails to pass the ICEMA written exam on the first attempt will have to pay the ICEMA approved fee and re-take the exam with a minimum score of 85%.
   b. A candidate who fails to pass the ICEMA written exam on the second attempt will have to pay the ICEMA approved fee, and provide documentation of eight (8) hours of remedial training in relation to ICEMA protocols, policies/procedures given by their PLN and pass the ICEMA exam with a minimum score of 85%.
   c. If the candidate fails to pass the ICEMA exam on the third attempt, the ICEMA Medical Director will review the candidate's application to determine additional training requirements.
7. The individual may then function as a provisional MICN under the direct supervision of either the Base Hospital MD, PLN, or ICEMA approved designee. The supervising individual must sign all MICN call forms.
8. The PLN will choose three (3) tapes for review (one trauma, one medical and one other).
9. When three (3) tapes meet ICEMA criteria, a MICN card will be issued with the same expiration date as the candidates RN license.
10. Failure to complete the entire process within one (1) year of application date constitutes failure of the entire process. The timeframe may be extended by the ICEMA Medical Director upon receipt of a request in writing from either the candidate or PLN outlining any extenuating circumstances.

APPROVED:

MAR 0 8 2006
San Bernardino Co. Health Officer Date

3/4 06
Mono Co. Health Officer Date

2-28-06
ICEMA Medical Director Date

James Richardson MD 3/16/06
Inyo Co. Health Officer Date

Virginia Hastings 3/23/06
ICEMA Executive Director Date